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040 HEC ‡c HEC
041 eng
090 RA413.5.U5 ‡b M43 2002
090
049 HECA
245 00 Medicare beneficiaries who involuntarily disenroll from their health plans : ‡b final report / ‡c by Bridget Booske ... [et al.]
260 Madison, Wisc. : ‡b Center for Health Systems Research & Analysis, University of Wisconsin at Madison ; ‡a Research Triangle Park, N.C. : ‡b RTI International, ‡c [2002]
300 iii, 86 p. : ‡b ill. ; ‡c 28 cm.
500 Supported by CMS contract no. 500-95-0061.
500 "March 2002."
504 Includes bibliographical references (p. 33).
650 0 Health maintenance organizations ‡z United States.
650 0 Managed care plans (Medical care) ‡z United States.
650 0 Health insurance ‡z United States.
650 0 Health services accessibility ‡z United States.
650 0 Medicare.
650 0 Health surveys ‡z United States.
650 0 Medicare beneficiaries.
700 1 Booske, Bridget.
710 2 Centers for Medicare & Medicaid Services (U.S.)
710 2 University of Wisconsin--Madison. ‡b Center for Health Systems Research and Analysis.
710 2 RTI International.

006 fields for Books Book					
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GPub o	**Conf** 0	**Fest** 0	**Indx** 0	**LitF** 0	**Biog**

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Medicare Beneficiaries Who Involuntarily Disenroll From Their Health Plans

Final Report

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CMS Contract No. 500-95-0061

March 2002

This project was funded by the Centers for Medicare & Medicaid Services under contract no. 500-95-0061. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. The contractor assumes responsibility for the accuracy and completeness of the information contained in this report.

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EXECUTIVE SUMMARY

The Balanced Budget Act (BBA) of 1997 expanded the health care options potentially available to Medicare beneficiaries through the establishment of Medicare+Choice, allowing Medicare beneficiaries to enroll in a variety of private health care options beyond the original Medicare fee-for-service program. However, although the BBA 1997 increased the health.care provider options available to seniors, representatives of the managed care industry maintain that the BBA's payment reforms along with new administrative requirements for Medicare+Choice organizations have led to the withdrawal of many managed care organizations from the Medicare market (GAO, 2001). In January 1999, 407,000 beneficiaries (about 6.5% of 1998 Medicare+Choice enrollees) were forced to make new choices about their health plan coverage when their Medicare health care plan withdrew from the program or reduced their service areas. In 2000, 327,000 beneficiaries (5% of Medicare+Choice enrollees) were affected by plans' withdrawals or reduction in service areas. In 2001, 934,000 Medicare beneficiaries (15% of total enrollment in Medicare+Choice) were affected and in 2002, 536,000 (10% of Medicare+Choice enrollees) were affected.

The effect of withdrawals by Medicare managed care plans, at the individual beneficiary level, can be particularly disruptive if beneficiaries have to change providers and break the chain of continuity in their care. Few studies have documented the experiences these involuntary disenrollees have in accessing information about their Medicare choice options when making a new decision (Kaiser Family Foundation, 1999; General Accounting Office, 1999; Gold and Justh, 2000, reporting on the Monitoring Medicare+Choice Project of Mathematica Policy Research funded by Robert Wood Johnson Foundation). For that reason, the Centers for Medicare & Medicaid Services (CMS) decided to conduct a survey to assess the ongoing impact of Medicare managed care market withdrawal on beneficiaries. Of particular interest was beneficiaries' understanding of their coverage options when their plans withdrew and the impact on their coverage and care.

The 2001 Survey of Medicare Beneficiaries who Involuntarily Disenroll From Their Health Plans was conducted for the Centers for Medicare & Medicaid Services (CMS), by the Center for Health Systems Research & Analysis (CHSRA) at the University of Wisconsin–Madison and RTI International in the winter/spring of 2001. The purpose of this survey was to collect data that will help CMS understand how Medicare beneficiaries are affected by Medicare health plan withdrawals and reductions in service areas. Understanding the difficulties some beneficiaries may have in response to changes in the health care system will help CMS meet its goal of providing all Medicare beneficiaries with adequate health care.

The survey included a sample of Medicare beneficiaries who were enrolled in managed care plans that either terminated their risk contracts or reduced their service areas as of January 1, 2001. The survey was conducted as a mail survey with telephone follow-up of nonrespondents. The sample included a total of

4,732 Medicare beneficiaries whose managed care health plan stopped serving them at the end of 2000. Data were collected between March and June of 2001, achieving an overall response rate of 83.7%.

The survey sample was stratified into three groups of beneficiaries: those who lived in areas where another Medicare managed care plan was available after December 31, 2000 (who accounted for about four of every five beneficiaries affected by the plan withdrawals), those who lived in areas where there were no Medicare managed care plans available (one in five affected beneficiaries), and a separate sample of beneficiaries with End Stage Renal Disease (ESRD). ESRD patients may be especially adversely impacted by plan withdrawals because they tend to have high health care expenses and, at the time that the survey was designed, they were not permitted to enroll in other managed care plans.

Two versions of the survey questionnaire were used in the survey – one for sample members who did not have ESRD and the other for those who did. Both questionnaires contained the same questions, except for three additional questions on the ESRD questionnaire. Of the 4,732 Medicare beneficiaries in the sample, 2,772 beneficiaries resided in areas where another Medicare managed care plan was available after December 31, 2000 and 1,422 beneficiaries lived in areas where there were no Medicare managed care plans available. The survey sample also included 538 beneficiaries with End Stage Renal Disease (ESRD). A total of 3,780 beneficiaries completed the questionnaire by mail or by phone: 2,215 resided in areas where another Medicare managed care plan was available; 1,195 beneficiaries lived in areas where there were no Medicare managed care plans available; and 370 were beneficiaries with ESRD.

Key findings from the analyses of the survey responses include the following:

INFORMATION AND NEW COVERAGE ARRANGEMENTS

- Sixty-six percent of beneficiaries affected by the January 1, 2001 plan withdrawals and service area reductions first found out that their plan would stop covering them from the plan itself. The media (newspaper, radio or TV) was the next most common source of information.
- Thirty-five percent of the beneficiaries felt they did not have enough information about their options for alternative coverage. Those who are disabled, people in the all other racial group or Hispanic, or in poor to fair health were more likely to report that they did not have enough information.
- Twenty-eight percent thought that when their plan stopped covering them they would end up with no insurance.
- Those with the lowest levels of understanding of the implications of their plan's withdrawal included people in the all other racial groups and Hispanics and those who did not complete high school.
- Disabled, people in the all other racial group (other than White), and less-educated beneficiaries and those in fair or poor health including those with end stage renal disease were less likely to be aware of supplemental health insurance options.
- Beneficiaries who reported having enough information to select alternative coverage were far more likely to understand the implications of their plan's withdrawal and to be aware of their coverage options.

- After their former plan withdrew from Medicare, about half of all beneficiaries reported that they were enrolled in another HMO. Beneficiaries who indicated they had received enough information were more likely to enroll in an HMO than those who did not get enough information. Beneficiaries in areas without a Medicare HMO were more likely to report having supplemental insurance than others. Disabled and people in the all other racial group or Hispanic beneficiaries were less likely to have supplemental insurance and more likely to only have Original Medicare coverage.

BENEFICIARY IMPACTS

- Over 60% of beneficiaries were somewhat or very concerned that they would have to change their personal doctor or nurse when their plan stopped covering them; 21% reported that they had to change their personal provider.
- Seventy-one percent of beneficiaries were somewhat or very concerned that they would no longer be able to pay for their health care.
- Disabled, less-educated, people in the all other racial group (other than White non-Hispanic) or Hispanic beneficiaries and those in poor or fair health were more likely to be very concerned about getting care than other beneficiaries. Having enough information about the plan withdrawals was clearly associated with reduced concerns.
- Fifty-six percent of all beneficiaries reported paying higher monthly premiums under their new coverage, 26% paid about the same amount or paid no premiums before and after the plan withdrawals, and 8% paid less. Those in vulnerable subgroups were less likely to report paying higher premiums, at least in part due to the fact that beneficiaries in these groups were less likely to have supplemental insurance and thus were not paying additional premiums.
- Beneficiaries who live in counties without another Medicare HMO were even more likely to report higher premiums than those in counties with a Medicare HMO option due to having supplemental coverage rather than being enrolled in an HMO. They were also more likely to indicate that their new insurance did not pay for the cost of prescription medicine.
- Three out of four beneficiaries reported that their former plan paid all or some of the cost of their prescription medicines whereas, after the plans withdrew, this dropped to one out of two.
- Beneficiaries in poor or fair health were more likely to report paying more for prescription medicines than those in good to excellent health.
- Forty percent of all beneficiaries reported that they were seeing a specialist when they were in their former plan. When their plan stopped covering them, 22% of these people (or 9% of all beneficiaries) had to stop seeing their specialist. Beneficiaries in areas with another HMO were more likely to indicate that they had to stop seeing their specialist than those in counties without an HMO. Beneficiaries with ESRD were more likely to report that they were seeing a specialist but less likely to report that they had to stop seeing this specialist when their former plan withdrew.
- Eleven percent of beneficiaries reported having had trouble getting the health care they wanted or needed but 22% reported delaying seeking medical care because they were worried about the cost. Fifteen percent reported that they did not get some prescribed medicines since leaving their former plan. The disabled, beneficiaries in the all other racial group (including Hispanic beneficiaries), and those in poor or fair health were all more likely to report problems with access to care.

The 2001 Survey of Involuntary Disenrollees shows that the withdrawal of plans from the Medicare program affected beneficiaries psychologically, financially, and/or in terms of their health care. Of most concern is the disproportionate effect of these withdrawals on the most vulnerable. HMOs that stay in the

Medicare market may continue to offer an attractive alternative to original Medicare, however, if and when plans leave Medicare, thousands of disabled, minority, less educated, and sick beneficiaries are left uncertain about their options, worried about costs (particularly of prescription medicines), and less likely to get needed care. One strategy that seems to ameliorate some but not all of these problems is the provision of information about what will happen when a plan leaves and what, if any, options are available. This information must be tailored to meet the needs of specific vulnerable subgroups such as the disabled and less educated.

INTRODUCTION

BACKGROUND

The Balanced Budget Act (BBA) of 1997 expanded the health care options potentially available to Medicare beneficiaries through the establishment of Medicare+Choice, allowing Medicare beneficiaries to enroll in a variety of private health care options beyond the original Medicare fee-for-service program. However, although BBA 1997 increased the health care provider options available to seniors, the payment rates to plans were lower than expected (Cooper, 1998). These rates, and other factors resulting from BBA 1997 requirements, may have initiated the withdrawal of many managed care organizations from the Medicare market.

The effect of withdrawals by Medicare managed care plans, at the individual beneficiary level, can be particularly disruptive, as beneficiaries have to change providers and break the chain of continuity in their care. Medicare health care plan withdrawals resulted in 407,000 beneficiaries (about 6.5% of 1998 Medicare+Choice enrollees) making a plan change in January 1999. In 2000, 327,000 beneficiaries (5% of Medicare+Choice enrollees) were affected by plans' withdrawals or reduction in service areas. In 2001, 934,000 Medicare beneficiaries (15% of total enrollment in Medicare+Choice) were forced to make new choices about their health plan coverage when their Medicare health care plan withdrew from the program or reduced their service areas. Most recently, 536,000 (10% of Medicare+Choice enrollees) were affected in 2002.

Few studies have documented the experiences these involuntary disenrollees have in accessing information about their Medicare+Choice options when making a new decision (Kaiser Family Foundation, 1999; General Accounting Office, 1999; Gold and Justh, 2000, reporting on the Monitoring Medicare+Choice Project of Mathematica Policy Research funded by Robert Wood Johnson Foundation). For that reason, the Centers for Medicare & Medicaid Services (CMS) decided to conduct a survey to assess the ongoing impact of Medicare managed care market withdrawal on beneficiary coverage, and to determine how beneficiaries access resources to help them make informed decisions about their future coverage.

Most HMOs that participate in Medicare offer additional benefits outside the regular Medicare benefit package. Extra benefits commonly include low co-payments, prescription drugs, unlimited hospitalization, and preventive services. Many beneficiaries have come to rely on the extra benefits they receive from their HMO, particularly prescription drug coverage. Replacing these benefits through Medigap insurance is usually very expensive, and may be unaffordable for some. Joining another HMO or going to fee-for-service (FFS) may also force many beneficiaries to change doctors, creating dissatisfaction and disrupting existing patterns of care. There has therefore been concern among policy makers about the impact of the recent HMO withdrawals on the beneficiary population.

There were two previous national efforts specifically designed to assess the impact of the plan withdrawals and service area reductions on beneficiaries.[1] The first consisted of a survey sponsored by the Kaiser Family Foundation after the January 1999 withdrawals. A report based on the survey results indicated that although most disenrollees fared relatively well after their HMO withdrew from Medicare, many experienced a reduction in supplemental benefits, an increase in premiums, and/or disruptions in their care arrangements (Kaiser Family Foundation, 1999). Problems were disproportionately experienced by disabled beneficiaries, racial and ethnic minorities, the poor and near poor, and those reporting fair or poor heath. The second effort consisted of a telephone survey of several hundred beneficiaries conducted by the DHHS Office of the Inspector General (OIG). The survey covered enrollee notification; information and assistance in exploring new insurance options; what option beneficiaries selected; changes in benefits and costs; problems encountered; and satisfaction. The OIG survey was conducted twice, following the January 1999 and January 2000 withdrawals. These surveys did not find severe problems, but no analyses were done for vulnerable populations.

A third study, described by Gold and Justh (2000), involved a national sample of over 6,000 Medicare beneficiaries of whom 425 were in Medicare+Choice plans that stopped serving enrollees at the end of 1999. This survey was conducted as part of the larger Monitoring Medicare+Choice Project of Mathematica Policy Research, funded by the Robert Wood Johnson Foundation. A recent publication from this study summarizes the differences between plans that withdraw from Medicare+Choice and those that remain (Achman and Gold, 2002). Withdrawing plans tend to have lower enrollments, offer less-generous benefit packages, had less stable benefits from 1999 to 2000, and faced competition problems within their markets.

The purpose of the 2001 Survey of Medicare Beneficiaries who Involuntarily Disenroll From Their Health Plans was to investigate the impact of plan withdrawals on Medicare beneficiaries. This report describes the methods and the results of that survey, which was conducted for the Centers for Medicare & Medicaid Services by the Center for Health Systems Research & Analysis (CHSRA) at the University of Wisconsin–Madison and RTI International in the winter/spring of 2001. The appendices to this report contain information about data collection activities and non-response analysis (***Appendices A*** and ***B***), tables with results (***Appendix C***) and a copy of the survey questionnaires (***Appendix D***).

OVERVIEW OF THE STUDY

The 2001 Survey of Medicare Beneficiaries who Involuntarily Disenroll From Their Health Plans was conducted as a mail survey with telephone follow-up of nonrespondents. The sample included a total of 4,732 Medicare beneficiaries whose managed care health plan stopped serving them at the end of 2000. Of

[1] Another study looked at the impact of HMO withdrawals specifically on rural beneficiaries. University of Minnesota researchers surveyed 1,093 rural beneficiaries who lost HMO coverage in January 1999. The survey was conducted from February to May 2000.

these, 2,772 beneficiaries resided in areas where another Medicare managed care plan was available after December 31, 2000 and 1,422 beneficiaries lived in areas where there were no Medicare managed care plans available. The survey sample also included 538 beneficiaries with End Stage Renal Disease (ESRD). ESRD patients may be adversely impacted by plan withdrawals because they tend to have high health care expenses, and at the time that the survey was designed, they were not permitted to enroll in other Medicare managed care plans. Until the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) was enacted in December 2000, ESRD beneficiaries in nonrenewing plans could not join a new Medicare+Choice plan.[2] Since the implementation of BIPA, ESRD beneficiaries are allowed to enroll in another M+C plan if their plan terminates its contract with CMS. This provision applies to terminations occurring on or after the date of BIPA's enactment and retroactively to terminations on or after December 31, 1998.

Two versions of the survey questionnaire were used in the survey – one for sample members who did not have ESRD and the other for those who did. Both questionnaires contained the same questions, but the questionnaire for the ESRD sample contained three additional questions that were specific to ESRD patients. Data were collected between March and June of 2001.

[2] The main goal of BIPA was to increase payments to Medicare+Choice organizations to maintain and expand beneficiary access to Medicare+Choice plans. However, upon implementation of BIPA in March 2001, only seven Medicare+Choice organizations reentered counties from which they had previously withdrawn or expanded into new counties (GAO, 2001).

METHODOLOGY

THE SURVEY INSTRUMENTS

We designed two versions of the survey questionnaire: one targeted to sample members who did not have End Stage Renal Disease (ESRD) and the other targeted to those who did. Both questionnaires contained the same questions, with the ESRD questionnaire containing an additional three questions specifically related to dialysis treatment. Questionnaire topics included:

- Questions about the sample member's former health insurance;
- Choosing new health insurance;
- Questions about the sample member's current health insurance;
- Getting needed care since the sample member left their former plan;
- Impact on dialysis treatment (for ESRD sample members only); and
- Respondent health status and demographic characteristics.

SAMPLE SELECTION

For the non-ESRD population, a sampling frame was constructed which included all enrollees, as of October 1, 2000, in plans that terminated or reduced their service areas effective January 1, 2001. The reason for using a three-month window was to capture people who stayed in the plan until the end of the year, as well as those who may have left earlier, in the event that there were differences between these types of enrollees. All beneficiaries who lived outside the United States, deceased and institutionalized sample members were excluded from the sampling frame. Once the frame for the non-ESRD population was constructed, beneficiaries were assigned to one of two strata – those who lived in areas where another Medicare managed care plan was available after December 31, 2000, and those who lived in areas in which no other Medicare plan was available. A separate sample consisting of all Medicare beneficiaries who had ESRD who were affected by plans' withdrawals and reduction in service areas was selected. No stratum for these sample members was defined since, at the time that the study was designed, ESRD patients would not be able to enroll in another Medicare managed care plan even if other Medicare health plans were available in their area on January 1, 2001.

The sample sizes for the "choice" and "no choice" strata were based on a goal of obtaining 3,000 completed interviews with non-ESRD Medicare beneficiaries, and 385 completed interviews with Medicare beneficiaries with ESRD. The number of beneficiaries selected in each stratum is shown in ***Table 1***.

Table 1
2001 Survey of Involuntary Disenrollees Sample Size by Stratum

Stratum Number	Stratum Title	Sample Size
1	"Choice" included Medicare beneficiaries who lived in areas in which another Medicare health plan was available after December 31, 2000.	2,772
2	"No Choice" included Medicare beneficiaries who lived in areas in which no other Medicare health plan was available after December 31, 2000.	1,422
3	End Stage Renal Disease	538
Total		**4,732**

As indicated, the Survey of Involuntary Disenrollees was conducted as a mail survey with telephone follow-up with mail survey nonrespondents. Data collection activities, which are described in ***Appendix A***, resulted in an overall response rate of 83.7%. This response rate was calculated using the following formula:

> **Numerator** - the number of completed interviews.
> **Denominator** - All sample members in the sample ***minus*** those who were institutionalized or deceased, and those who reported that they were still enrolled in the sample plan or left the plan because they moved out of the plan's service area.

The responses rates by stratum and overall are shown in ***Table 2*** below.

Table 2
2001 Survey of Involuntary Disenrollees Response Rates by Stratum and Overall

Stratum Number	Stratum Title	Response Rate
1	"Choice" included Medicare beneficiaries who lived in areas in which another Medicare health plan was available after December 31, 2000.	82.8%
2	"No Choice" included Medicare beneficiaries who lived in areas in which no other Medicare health plan was available after December 31, 2000.	86.9%
3	End Stage Renal Disease	79.2%
Overall		**83.7%**

The results presented in this report are based upon weighted data. A weighting model was developed using an iterative process. On the first iteration the weights were the same as the design weights. In the initial sampling frame, there were 631,197 beneficiaries who resided in counties where another Medicare

HMO was available, 128,218 in counties without another Medicare HMO and 1,713 beneficiaries with ESRD who were enrolled on October 1, 2000 in plans that withdrew from the Medicare program or reduced their service areas effective January 1, 2001. The non-response model was then applied iteratively so that the last iteration provided the response propensity weights. Any case with a completed survey or any information about case status (i.e., beneficiaries who were identified as deceased) was included in this process. Non-respondents (who were not reached or who refused to participate) were assigned a weight of zero. At the end of that process, the weights summed up to the population of interest in each stratum since the design variable was always retained with the modeling. However, since some respondents may be deemed "ineligible," the final weights summed back to the *estimated total of the eligible population* and were close, but not identical, to the distribution in the initial sampling frame. The totals of the weights will thus always be less than the totals on the original sampling frame (unless everyone sampled is considered eligible). Additional information about weighting and the non-response analysis conducted on the survey sample is provided in ***Appendix B***.

DATA ANALYSIS

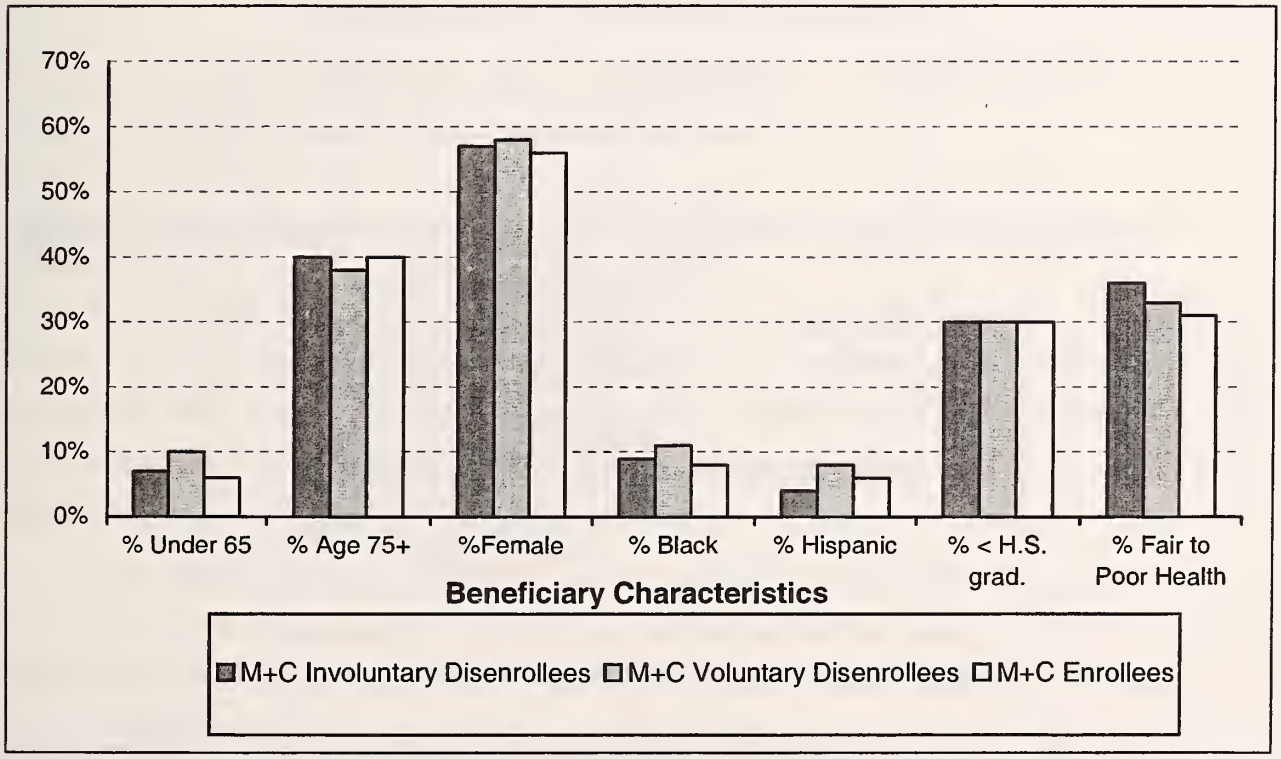
Descriptive statistics and chi-square tests of independence were used to assess statistical associations between a number of potential outcomes of the plan withdrawals and beneficiary characteristics. These outcomes include new coverage arrangements and the financial, psychological and care-related impacts of the plan withdrawals from the Medicare program. The complete set of descriptive statistics and statistical tests are provided in ***Appendix C***. Analyses were conducted using SUDAAN that appropriately account for the sample weighting approach in calculating standard errors. Findings of significance at the 99% probability level and differences of at least 10 percentage reports are highlighted in text and graphs in the subsequent sections of this report. In addition, where appropriate, results of multivariate analysis (using logistic regression) are reported to further examine the relationships between beneficiary characteristics and the impact of plan withdrawals. ***Tables C20-C23*** in ***Appendix C*** provide the full specifications for significant logit models with a minimum Cox & Snell R-Square of at least 0.10 or where the model increases the likelihood of prediction from the logistic model by at least 10% (versus a model that simply assigns all responses to the most frequent response category). Additional variables used in the logistic regression analyses, such as the Medicare Managed Care penetration rate groups and the payment rates that Medicare+Choice organizations receive per enrollee per month, were derived from CMS files available to the public at www.cms.gov.

INFORMATION AND COVERAGE DECISIONS

WHO ARE AFFECTED BY PLAN WITHDRAWALS?

Table C.1 in *Appendix C* shows the characteristics of the three sample groups of beneficiaries who responded to the survey: those who lived in a county with a choice of another Medicare HMO, those in a county without another Medicare HMO alternative, and those with End Stage Renal Disease (ESRD). The "Total" column represents weighted data from all three strata. Thus the total columns in tables in this report reflect the weighted mix of those in counties with and without a Medicare HMO (as of January 1, 2001) and of those with ESRD, i.e., in proportion to the composition of the entire population of involuntary disenrollees. Compared to voluntary disenrollees (people who leave Medicare HMOs of their own accord) and enrollees (those who stay in an HMO), involuntary disenrollees (those in plans that leave the Medicare program) are similar in age, gender and education but more likely to report their health to be fair or poor and less likely to be Hispanic (*Figure 1*).

Figure 1
Comparison of involuntary disenrollees to voluntary disenrollees and enrollees, 2000-2001



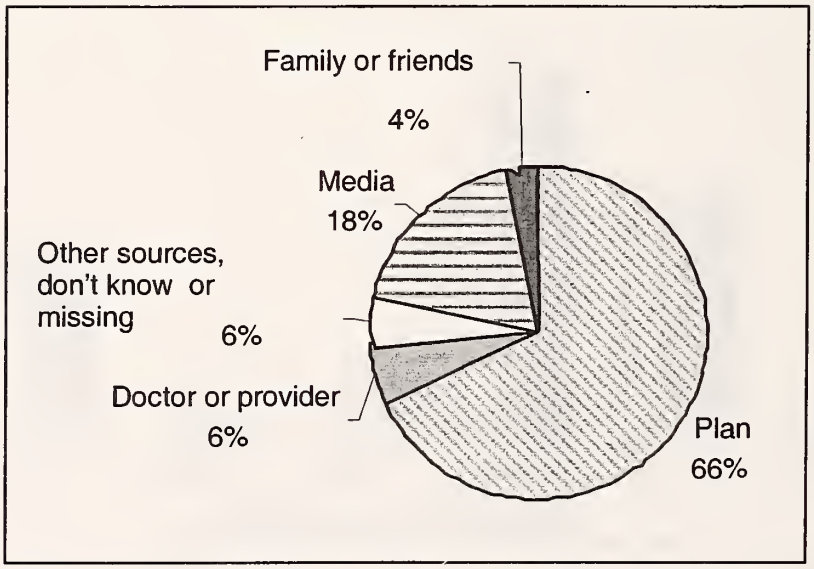
Source: 2001 Survey of Involuntary Disenrollees and 2000 Consumer Assessment of Health Plans Surveys for Medicare Managed Care and Medicare Disenrollment

Overall, 92% of the beneficiaries responding to the survey reside in a metropolitan county (***Table C.1***) compared to 76% of Medicare beneficiaries nationally (Achman and Gold, 2002). However, there was a significant difference between the geographic location of the choice and no-choice strata: only 3% of those with a choice of another HMO lived in a non-metropolitan area while 34% of the beneficiaries without another HMO available live in non-metropolitan counties.

INFORMATION ABOUT PLAN WITHDRAWALS

About two-thirds of beneficiaries first found out that their plan was going to stop covering them from the plan itself (***Figure 2*** and ***Table C.2***). The next most common source of information about the plan withdrawal came from the media, i.e., newspapers, radio or television. Less educated beneficiaries and those in the all other racial group were less likely to have first heard the news from media sources. Ninety-six percent of beneficiaries recalled receiving a letter at some point from the plan about its impending withdrawal.[3]

Figure 2
First source of information about plan withdrawal



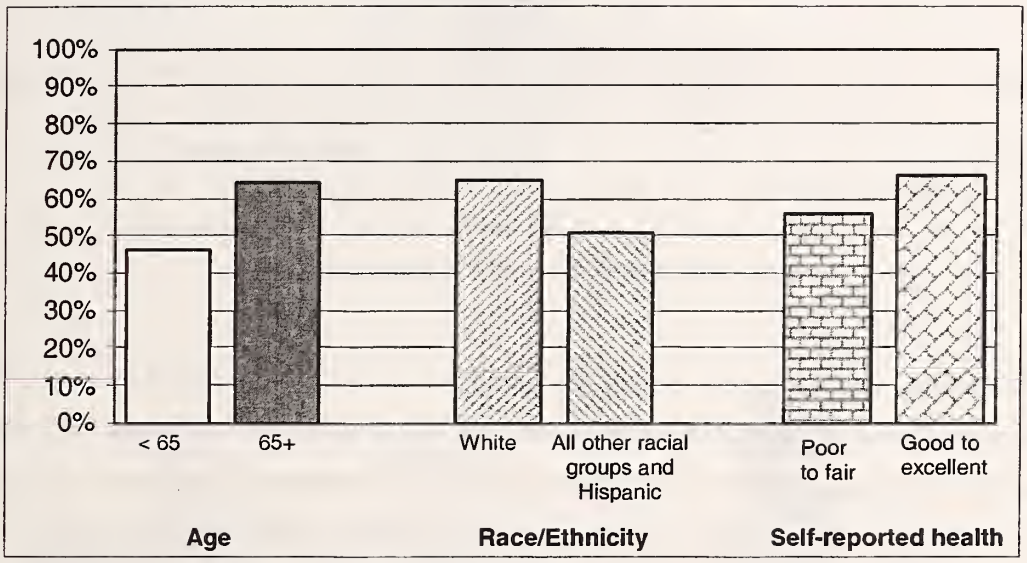
Source: 2001 Survey of Involuntary Disenrollees

Over a third of the beneficiaries indicated they did not have enough information about their options when their plan stopped covering them (***Table C.2***). Disabled beneficiaries (those under 65 years of age) and the oldest beneficiaries were less likely to indicate that they received enough information about their coverage

[3] This rate is significantly higher than the number of involuntary disenrollees in the Abt Associates' case studies who recalled receiving a letter from their plan. Abt found that about 75% of beneficiaries recalled receiving a letter from their plan.

options when they heard that their plan would stop covering them. Compared to other racial/ethnic groups, African-American beneficiaries were less likely to indicate that they had received enough information. Those in poor or fair health were also less likely than healthier beneficiaries to indicate that they received enough information about their coverage options (*Figure 3* and *Table C.3*).

Figure 3
Percentage of beneficiaries indicating that they had enough information



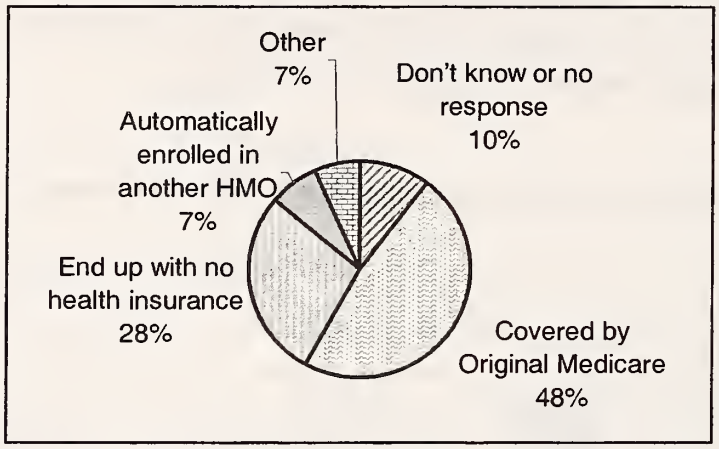
Source: 2001 Survey of Involuntary Disenrollees

UNDERSTANDING IMPLICATIONS OF PLAN WITHDRAWAL AND NEW COVERAGE OPTIONS

Less than half of the beneficiaries thought that when their plan stopped covering them the Original Medicare plan would cover them (*Figure 4* and *Table C.4*). Over a quarter thought they would end up with no health insurance. Some beneficiaries thought they would be automatically enrolled in another HMO while only 2% thought they would be able to select a new plan. One in ten beneficiaries either indicated that they did not know what would happen or did not respond to the question.

With regard to whether or not there was another Medicare HMO available to them, 52% of those who lived in an area with another HMO reported that there was another HMO available to them (*Table C.4*). Fifty percent of those in an area without another HMO indicated that there were no other HMOs available. Knowledge of the availability of supplemental insurance was more common: 68% of beneficiaries were aware of the availability of supplemental insurance. Disabled (those under 65 years of age) beneficiaries, older beneficiaries, people in the all other racial group (including Hispanic beneficiaries), and less educated beneficiaries were the least likely to report availability of supplemental insurance options (*Table C.5*).

Figure 4
Beneficiary understanding of the implications of plan withdrawal



Source: 2001 Survey of Involuntary Disenrollees

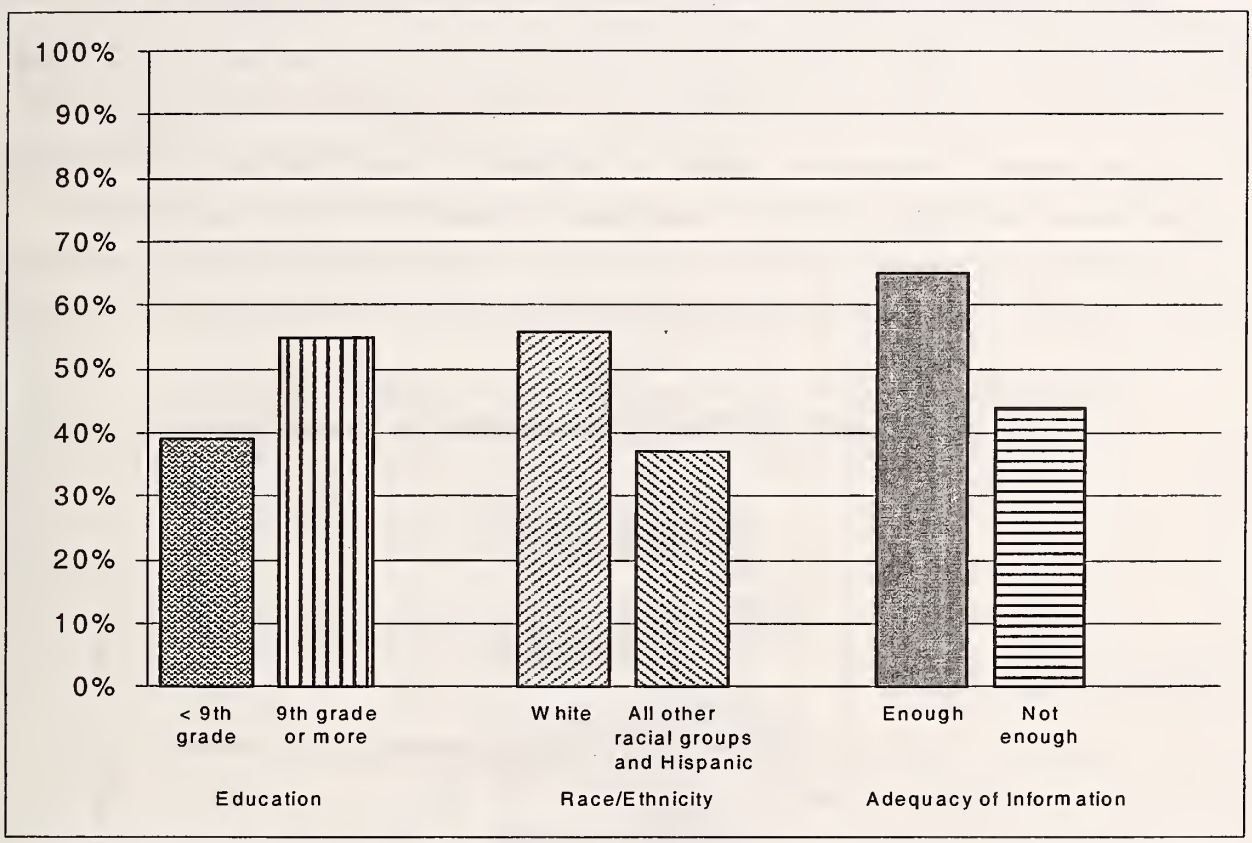
Beneficiaries in counties with another Medicare HMO available who stated that no other HMOs are available may be correct. Some HMOs are at capacity and not accepting new enrollments[4], and others only cover parts of counties (particularly group and staff models). The definition of whether a county offered a "choice" or not reflects whether or not there was a choice of another Medicare+Choice HMO as of January 1, 2001. Subsequently a few plans did expand their service into counties. Also, the definition does not account for the availability of cost contract or private fee-for-service plans or of HMO coverage that is offered to beneficiaries by a current or former employer or via participation in Medicaid. In addition, some beneficiaries may not understand that if they continue to see a provider that was affiliated with their former HMO, their services may now be covered under the Original fee-for-service Medicare (otherwise referred to as Original Medicare). Similarly, responses to the question on availability of supplemental options may reflect beneficiary experiences with health screening, i.e. some may have been turned down, and so the insurance is "unavailable" although it is likely that some of these responses reflect misunderstandings on the part of respondents about what options are available to them.

From beneficiaries' responses to the question about what would happen when their plan stopped covering them, we derived a measure of the percentage that understood what would happen when their plan withdrew (***Table C.5***). Those who thought that they would be covered by the Original Medicare plan, covered through their current or former employer, or who thought they would be able to select a new plan

[4] Health plans can request capacity limits be established prospectively to be applied when their enrollment reaches a certain level or they can request that their enrollment level be limited to the number of beneficiaries currently enrolled. Consequently, at any point in time a plan with "capacity limits" may or may not actually be accepting new enrollees.

understood what would happen.[5] Conversely, those who thought that they would end up with no health insurance or that they would be automatically enrolled in another HMO apparently did not understand the implications of their plan's decision to stop covering them.[6] Just over half of beneficiaries appeared to understand exactly what would happen when their plan left the Medicare program (*Table C.5*). There was less understanding of what would happen among less educated and people in the all other racial group or Hispanic beneficiaries (*Figure 5* and *Table C.5*).

Figure 5
Percentages of beneficiaries who understood the implications of plan withdrawal



Source: 2001 Survey of Involuntary Disenrollees

In addition, beneficiaries who reported that they had received enough information about the plan withdrawals were far more likely to understand what would happen than those who did not indicate that they had enough information (*Table C.5*).

[5] Those who thought they would "have to purchase supplemental insurance" may indicate a belief on the part of the respondent that prudence or financial necessity demanded the purchase of supplemental insurance rather than it being a legal or program requirement. Consequently, these individuals were also considered to have understood what would happen.

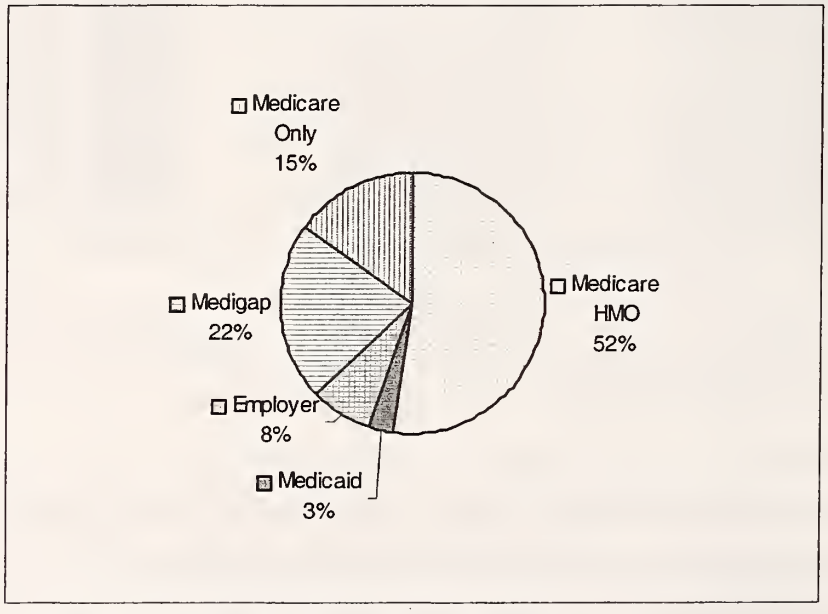
[6] Those who did not respond to this question or whose responses could not be coded were classified as not understanding.

NEW COVERAGE ARRANGEMENTS

Two-thirds of the beneficiaries were somewhat, very or extremely satisfied with the amount of time that they had to choose new health insurance. This did not differ significantly across the different sample groups. Fifty-five percent of the beneficiaries indicated that they made health insurance decisions alone while 39% indicated they made decisions in conjunction with someone else such as a family member, friend or insurance counselor (***Table C.6***).

Beneficiaries were asked about their new coverage arrangements following their plan's withdrawal from Medicare (***Figure 6*** and ***Table C.7***). Respondents could indicate coverage under more than one arrangement so a hierarchical approach was used to assign them to the types of coverage. If respondents reported enrollment in a Medicare HMO, they were assigned to this category. For the remaining respondents (those who did not report enrollment in an HMO), if they reported that Medicaid covered them, they were assigned to this category. This process was repeated for each category so that the final category represented all respondents who did *not* report that they were enrolled in a Medicare HMO, were covered by Medicaid, were not covered through a current or former employer, and had no supplemental health insurance. Thus, we designated these respondents as covered by Original Medicare only.

Figure 6
Beneficiaries' reports of new coverage arrangements after plan withdrawals



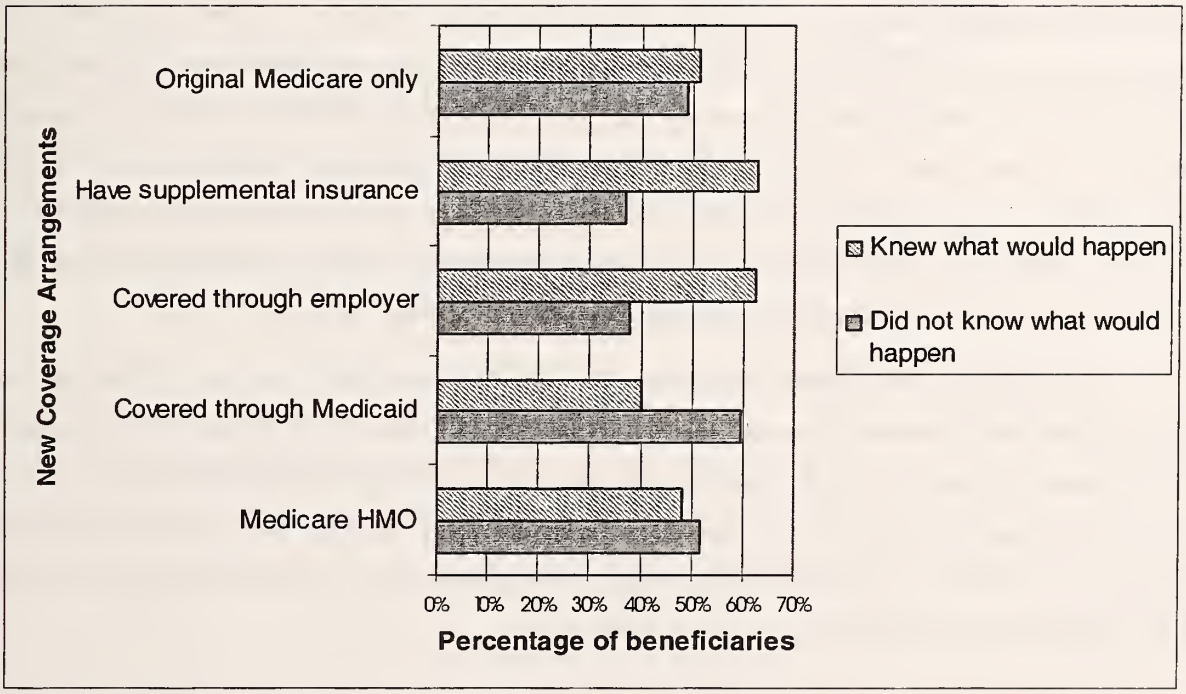
Source: 2001 Survey of Involuntary Disenrollees

These frequencies are based on beneficiaries' reporting of their current health insurance coverage -- these frequencies often do not correspond with administrative data. Consequently, caution is advised in interpreting these numbers, e.g., the 34% of beneficiaries who live in an area without another Medicare HMO

but reported belonging to an HMO. In general, there was over 90% agreement between CMS enrollment records and beneficiaries' reports of *not* being in an HMO. However, when beneficiaries reported that they do belong to an HMO, CMS records only confirmed HMO membership in about 50% of these cases. As noted earlier in the report, there are several potential reasons why beneficiaries may report membership in an HMO that is not confirmed by administrative records. Some may receive services from HMO providers on a fee-for-service basis. Others may continue to get certain benefits from an HMO through their former employer or union, even if they are not formally enrolled under a Medicare risk contract. Of the beneficiaries who live in an area without another Medicare HMO, CMS administrative files showed no record of Medicare+Choice enrollment for 80% of the beneficiaries who reported HMO membership. Of the remaining 80 beneficiaries, administrative records showed that as of January 1, 2001, 27 were enrolled in cost plans and 24 enrolled in a private fee-for-service plan. Neither cost plans nor private fee-for-service plans were included in the definition of the choice/no-choice counties.

Beneficiaries who did not understand the implications of the plan withdrawals were less likely to report being covered through their employer or to report other supplemental insurance than those who understood what would happen when their plan withdrew (***Figure 7***).

Figure 7
Beneficiaries' reports of new coverage arrangements and understanding of implications of plan withdrawals



Source: 2001 Survey of Involuntary Disenrollees

While over half of all beneficiaries reported membership in an HMO, this proportion was not constant across the three sample strata (***Table C.7***). Beneficiaries in counties without a Medicare HMO and beneficiaries with ESRD were far less likely to report membership in an HMO. In fact, since only 38% of ESRD beneficiaries reported membership in an HMO (similar to the level for those in counties without Medicare HMOs), this suggests that few ESRD beneficiaries have benefited so far from the legislative changes in the Benefits Improvement and Protection Act (BIPA) of 2000.[7] By far the most significant predictor of whether a beneficiary reported enrollment in another HMO in multivariate modeling was the market penetration of Medicare managed care in their county (***Table C.21***). None of the beneficiary demographic characteristics were associated with a significant increase or decrease in the likelihood of reporting enrollment in another HMO. The odds of CMS Region 6 beneficiaries[8] reporting enrollment in another HMO were 28% lower than those for beneficiaries living elsewhere in the United States (***Table C.21***). A logistic regression model of administrative records of HMO enrollment produced similar results with respect to market penetration; however, Region 6 was not significant in this model (***Table C.22***). Beneficiaries who indicated that they had received enough information about the plan withdrawals were more likely to enroll in an HMO, according to administrative records, than those who said they did not get enough information (***Table C.22***).

A number of beneficiaries who live in an area without another Medicare managed care health plan reported membership in an HMO. This could be due to coverage by a current or former employer, participation in Medicaid, or because some beneficiaries continue to see a provider that was affiliated with their former HMO with their services now covered under fee-for-service Medicare. Other beneficiaries may have coverage under a Medicare cost contract or be enrolled in a private fee-for-service plan and mistake this for an HMO. Also, the designation of "orphan" status, i.e., having no other Medicare HMO available, was effective as of January 1, 2001, while a small number of plans may have signed up after this date (e.g., in Texas, New York, and New Mexico, plans added counties as of March 1, 2001).

Those living in areas without a Medicare HMO and those with ESRD were far more likely to report having supplemental insurance than beneficiaries in areas with a Medicare HMO (***Table C.7***). Beneficiaries who indicated that they had enough information about the plan withdrawals and those with more education were also more likely to report that they have supplemental coverage. Disabled beneficiaries (those under age 65), people in the all other racial group, Hispanic beneficiaries, and those living in CMS Region 6 were all less likely to report having supplemental insurance (***Table C.23***).

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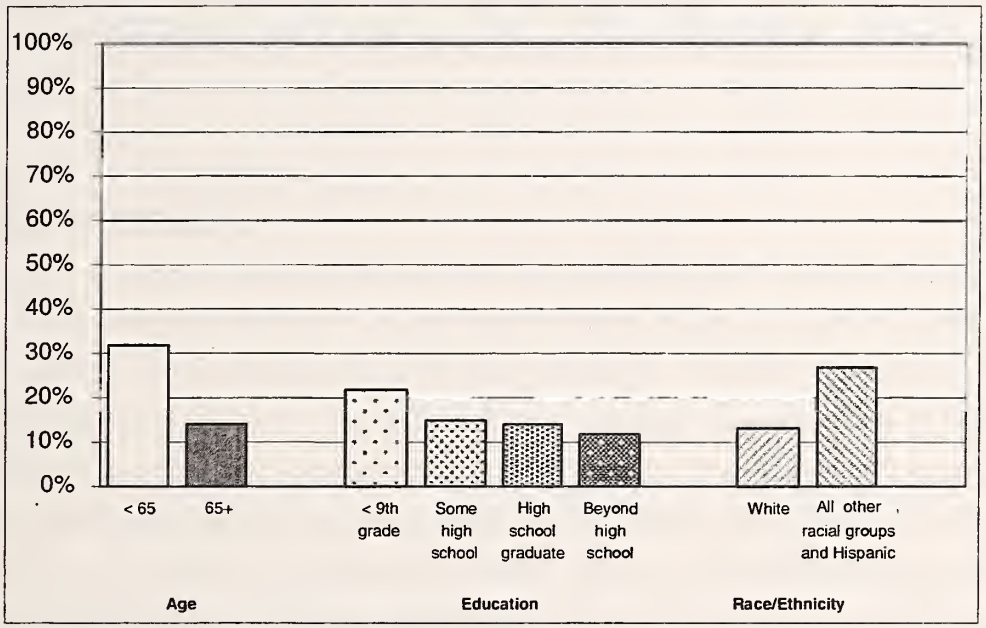
[7] CMS records actually only confirmed reports of HMO enrollment for 11% of the 38% of ESRD beneficiaries who reported enrollment in a M+C plan.

[8] Arizona, Louisiana, New Mexico, Oklahoma, and Texas

Those in vulnerable subgroups such as the disabled, less educated, and people in the all other racial group or Hispanic beneficiaries were more likely to only have Original Medicare coverage after their plan withdrew (***Figure 8*** and ***Table C.8***).[9] The most frequent reason cited for not having supplemental insurance was that it costs too much (***Table C.9***).

Figure 8
Percentage of beneficiaries reporting only Original Medicare coverage after plan withdrawal



Source: 2001 Survey of Involuntary Disenrollees

[9] Bivariate results are highlighted in the text rather than the multivariate results since the multivariate model using logistic regression to predict whether a beneficiary reported only having traditional Medicare coverage was not as significant as other models derived from this study. The results of the logistic regression are, however, included in Appendix C in Table C.23. The model provide support for the results from the subgroups reported from the bivariate analysis and suggest that those in other vulnerable subgroups such as those in poor or fair health and those without adequate information may also be more likely to have only original Medicare without supplemental coverage.

IMPACT OF PLAN WITHDRAWALS ON BENEFICIARIES

This chapter summarizes the impact of plan withdrawals on beneficiaries' care and provider arrangements. For example, the survey asked beneficiaries about their satisfaction with their new coverage following the withdrawal of their former plan from Medicare (***Table C.10***). About one third (37%) of beneficiaries indicated that they were less satisfied with their insurance coverage now. The disabled (those under age 65) were the only subgroup that were significantly more dissatisfied than others – over half (53%) of the disabled reported being less satisfied with their coverage now (compared to 36% of those aged 65 and over) (***Table C.11***).

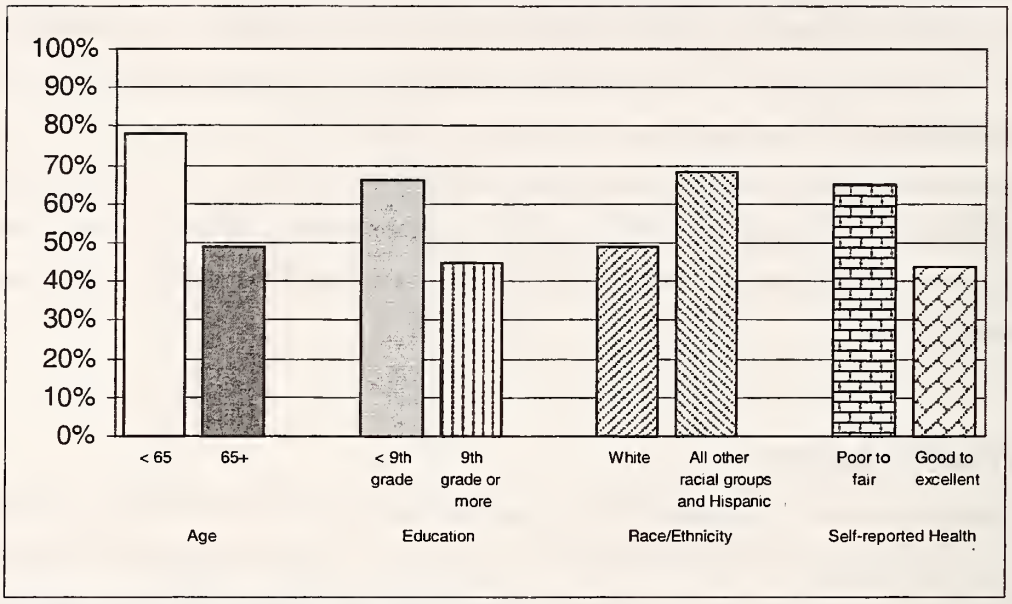
PSYCHOLOGICAL IMPACT

Another set of questions addressed the concerns that beneficiaries faced when they found out that their plan was withdrawing from Medicare. Concerns about having to change their personal doctor or nurse weighed on the minds of the beneficiaries affected by plan withdrawals. Over 60% were either somewhat or very concerned about this (***Table C.12***). Beneficiaries living in counties with another Medicare HMO were more concerned than beneficiaries in counties without an HMO option. Even more beneficiaries reported having concerns about being able to pay for their health care (71% somewhat or very concerned) or about getting care that they needed (69%). Respondents in counties with or without another Medicare HMO appeared not to differ with respect to concerns regarding ability to get or pay for care. However, there were significant differences between various subgroups with the more vulnerable beneficiaries expressing more concerns about their ability to get or pay for care after their plan withdrew: the disabled, those with less than a 9th grade education, people in the all other racial group or Hispanic beneficiaries, and those reporting poor or fair health were all more likely to report more concerns than other beneficiaries (***Figure 9*** and ***Table C.13***). In particular, when all other conditions are held constant, the odds of beneficiaries who are disabled being very concerned about getting care after their plan withdrew from Medicare are over 100% higher than those for aged beneficiaries. Information clearly reduced the likelihood of concerns: beneficiaries who did not have adequate information about the plan withdrawals were far more likely to have concerns about getting care than those with enough information (***Table C25***). Beneficiaries who live in non-metropolitan areas or areas with low Medicare managed care penetration were also more likely to be concerned.

FINANCIAL IMPACT

Over half (56%) of the beneficiaries who responded to the survey reported that they had to pay more in premiums after their plan withdrew (***Table C.14***). However, many HMOs that have remained in Medicare have increased premiums and reduced benefits in the last few years. In their continuing analysis of trends in

Figure 9
Percentage of beneficiaries reporting being very concerned about getting care



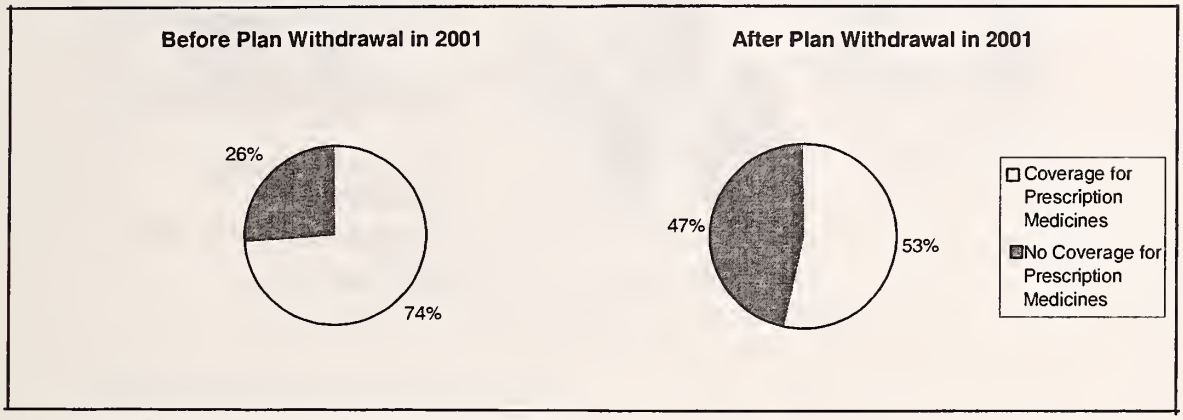
Source: 2001 Survey of Involuntary Disenrollees

benefits and premiums funded by the Commonwealth Fund, Achman and Gold (2002) noted that despite the congressional action to increase the payment rates that Medicare+Choice organizations receive, mean premium and cost-sharing levels in Medicare+Choice plans continued to increase in 2001. For example, average monthly premiums went from $14.43 in 2000 to $22.94 in 2001.[10]

From the bivariate analysis, only 39% of disabled beneficiaries reported paying more in premiums compared to 57% of aged beneficiaries between the ages of 65 and 84 years (***Table C.15***). Fewer disabled beneficiaries may have experienced increases in premiums because many are dually eligible for Medicare and Medicaid and pay no premium for Medicaid. However, when those who are dually eligible or have Medicare only are excluded and other characteristics are controlled for in a multivariate analysis, the odds of the disabled having to pay more for premiums were still lower than those of aged beneficiaries (***Table C.26***). Meanwhile other differences from the bivariate analysis such as those between racial/ethnic groups and between metropolitan and non-metropolitan residents were no longer significant in the multivariate analysis. The odds of beneficiaries with supplemental insurance reporting that they had to pay more for premiums after their plan withdrew were far greater when compared to beneficiaries reporting enrollment in another Medicare HMO (***Table C.26***). Compared to beneficiaries in other regions, the odds of beneficiaries from CMS Region 6 (Arkansas, Louisiana, New Mexico, Oklahoma and Texas) having to pay more for premiums were also higher.

Seventy-four percent of beneficiaries reported that their former plan paid all or some of the cost of their prescription medicines whereas, after the withdrawing plans stopped covering them, this percentage dropped to 53% (***Figure 10*** and ***Table C.14***). This compares to a decrease in the proportion of all Medicare+Choice enrollees with prescription drug coverage that went from 78% in 2000 to 70% in 2001 (Achman and Gold, 2002).

Figure 10
Percentage of beneficiaries reporting having coverage for prescription medicines



Source: 2001 Survey of Involuntary Disenrollees

The loss of prescription medicine coverage meant that 51% of involuntary disenrollees found themselves paying more for prescription medicines after their former plan withdrew from Medicare (***Table C.14***). Those who are disabled were significantly more likely to report paying more for prescription medicines than those who qualify for Medicare by being aged 65 or older (64% versus 45%) (***Table C.15***). Also, beneficiaries reporting that their health was fair or poor were more likely to report paying more for prescription medicines than those reporting good to excellent health (54% versus 44%). However, about one in ten beneficiaries did not know or did not answer questions about their prescription drug coverage before or after the plan withdrawals.

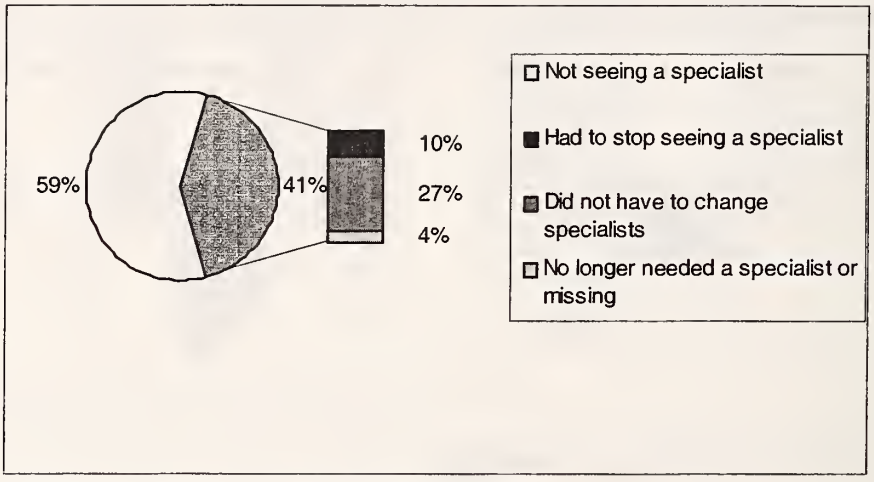
IMPACT ON PROVIDER ARRANGEMENTS

About one in five beneficiaries indicated that they had to change their personal doctor or nurse after their former plan stopped covering them (***Table C.16***). Nineteen percent of the beneficiaries who had to change their personal provider indicated that it was a big problem to find a new provider. Twenty-three percent of beneficiaries in metropolitan areas reported changing providers compared to 10% in non-metropolitan areas (***Table C.17***).

[10] These average monthly premiums are for all Medicare+Choice plans including those with zero premiums. In 2001, 46% of Medicare+Choice plans offered zero premium packages.

Four out of ten beneficiaries reported that they had been seeing a specialist when their plan stopped covering them (*Figure 11* and *Table C.15*). One in four of these beneficiaries (or 9% of all beneficiaries) reported that they had to stop seeing this specialist.

Figure 11
Percentage of beneficiaries reporting having to stop seeing a specialist after plan withdrawal



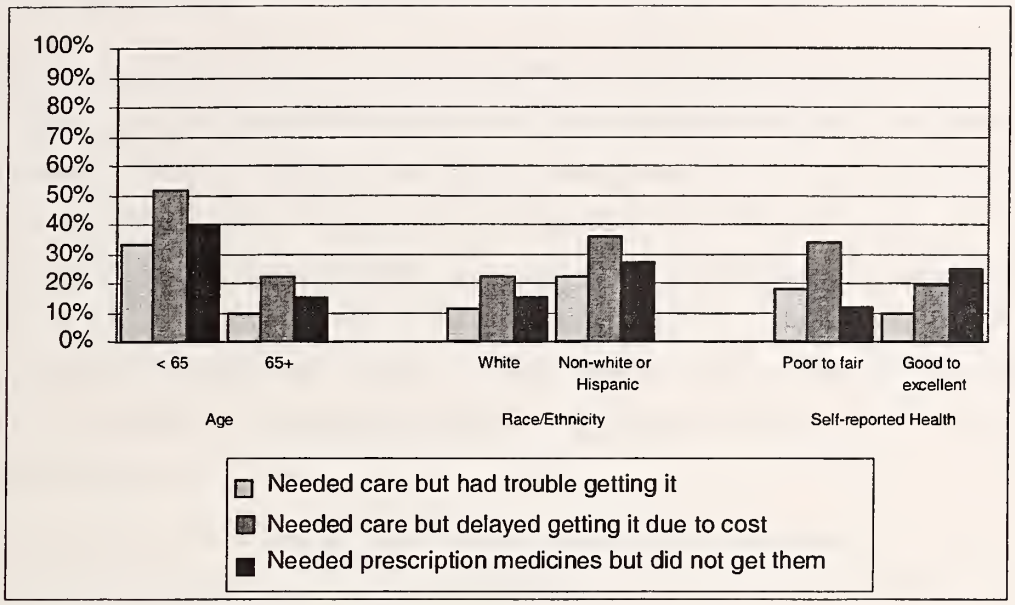
Source: 2001 Survey of Involuntary Disenrollees

IMPACT ON ACCESS TO CARE

Eleven percent of the involuntary disenrollees indicated that they had trouble getting care they wanted or needed since their plan stopped covering them (*Table C.18*). This compares to 4% of all Medicare beneficiaries in HMOs (unpublished data from the 1998 Medicare Current Beneficiary Survey). A larger percentage (22%), however, indicated that they had delayed seeking medical care because they were worried about the cost, compared to 3% of Medicare HMO beneficiaries. Fifteen percent reported that there were medicines prescribed for them that they did not get. Cost and the lack of insurance coverage were the most common reasons for not getting prescribed medicines.

There were clear and significant differences in problems with access to care (*Figure 12* and *Table C.19*) between the disabled and those aged 65 and over, between white non-Hispanic beneficiaries and people in the all other racial group and Hispanic beneficiaries, and between those who reported good to excellent health and those who reported themselves to be in poor or fair health.

Figure 12
Percentage of beneficiaries who needed care after plan withdrawal but had access problems



Source: 2001 Survey of Involuntary Disenrollees

With respect to the ESRD beneficiaries who responded to the survey, 88% were currently receiving dialysis treatments (***Table C.20***). Three percent of these beneficiaries had to change dialysis locations when their plan stopped serving them. Six percent of ESRD beneficiaries had to change to a new doctor for their kidney disease.

DISCUSSION AND IMPLICATIONS

The characteristics of involuntary disenrollees living in areas with and without a choice of another HMO were quite similar with one major exception: only 3% of beneficiaries affected by the 2001 plan withdrawals with a choice of another HMO lived in non-metropolitan counties, while 34% of beneficiaries without another HMO option lived outside of metropolitan areas. This difference highlights the continued disparity noted by Achman and Gold (2002) in choices available to metropolitan and non-metropolitan beneficiaries. In contrast to the similarities between beneficiaries in the other two sample strata, beneficiaries in the End Stage Renal Disease (ESRD) sample were quite different from those without ESRD: beneficiaries with ESRD were more likely to be female, African-American, in poor or fair health, and to have been hospitalized in the past year.

The findings show that there are some clear information and understanding gaps among beneficiaries, particularly those in more vulnerable subgroups, regarding the options available to them and the implications of plans withdrawing from the Medicare program. Letters from the nonrenewing plans were by far the most frequent first source of information about the plan withdrawal for the majority of disenrollees. The media (TV, radio, or newspaper) was the next most frequent source of information except for those in the more vulnerable subgroups such as the less educated and all racial groups other than white non-Hispanic. Disabled beneficiaries, people in the all other racial group, and those in fair or poor health were less likely to indicate they received enough information about the plan withdrawals. These same groups were less likely to be aware of the availability of supplemental health insurance. Other groups who were less aware of supplemental insurance options included less educated beneficiaries, particularly those with less than high school education. People in the all other racial group and less educated beneficiaries were also less likely than other beneficiaries to understand what would happen to them with respect to health care coverage when their plan left the Medicare program. About four in ten beneficiaries in the all other racial group (other than White) or beneficiaries with less than a high school education understood what would happen compared to half of all beneficiaries. Beneficiaries' reports of having enough information were clearly associated with their understanding of what would happen when their plan withdrew and awareness of supplemental health insurance options.

Compared to results from the Kaiser Family Foundation study of beneficiaries affected by plan withdrawals in January 1999, those affected by the January 2001 withdrawals were less likely to report enrollment in another HMO (52% in 2001 compared to 77% in 1999) even though similar proportions of beneficiaries still had an HMO option available to them (four out of five beneficiaries). As was true in 1999, reports of enrollment in another HMO were strongly related to the number of Medicare plans and their market penetration in an area. Furthermore, it should be noted that when compared to CMS enrollment

records, beneficiaries apparently overestimate membership in HMOs. Consequently, the true percentage that switches to another Medicare+Choice is less than that derived from survey responses.

After managed care's role in a local market, having enough information was the next most likely predictor of beneficiaries choosing to enroll in another HMO. As opposed to reverting to Original Medicare coverage, joining another HMO requires a conscious action on behalf of the beneficiary. Those who felt they did not have enough information may not have known that there was another HMO that they could join.

The other significant predictor of beneficiaries reporting HMO enrollment was living in a region other than Region 6. Even after accounting for the lower availability of plans to beneficiaries in Region 6 (the average number of plans for a Region 6 beneficiary was one versus two for beneficiaries in other parts of the country), beneficiaries in Region 6 were less likely to enroll in another HMO and they were also less likely to have supplemental insurance coverage. A more detailed examination in particular markets within Region 6 might shed some light on the particular environment that beneficiaries in this region face, e.g., Abt Associates' case studies of involuntary disenrollees identified a unique situation in Houston, TX in 2000 when the only remaining HMO in the area reached its capacity limit in September of that year and no longer accepted any new enrollees (Abt 2001). Stuber et al. (2002) also examined the Houston market in their case studies of seven markets from which Medicare+Choice plans withdrew. They noted the disruption of provider networks that often precedes a plan's decision to withdraw from a Medicare+Choice market: in Houston, 27% of primary care physicians left a plan's network after one year. Eighty-six percent of the Region 6 beneficiaries and 22% of all beneficiaries who responded to the 2001 Survey of Involuntary Disenrollees were from Texas.

Reports of supplemental health insurance were strongly related to low Medicare managed care penetration, i.e., beneficiaries with fewer managed care options did turn to supplemental insurance. However, beneficiaries in vulnerable subgroups, such as the disabled, less educated, and people in the all other racial groups or Hispanic beneficiaries, were less likely to report having supplemental insurance than other beneficiaries. Sixty-six percent of those with Original Medicare coverage only, i.e., without supplemental insurance, reported that they did not have supplemental insurance because it cost too much. This percentage was even higher (79%) for those in areas without a choice of another HMO. However, ESRD beneficiaries without supplemental insurance were almost as likely to cite not applying for it or thinking that they would be turned down as they were to cite its cost as the main reason for not having supplemental insurance. In addition to the financial barriers to acquiring supplemental coverage, lack of information appears to be a barrier to having supplement insurance. Those who indicated that they had enough information about the plan withdrawals were more likely to have supplemental coverage than those who did not have enough information.

In examining the impact of plan withdrawals on beneficiaries, we looked at the psychological and financial impact and the impact on provider arrangements and access to care. Approximately three out of every four beneficiaries reported that they were somewhat or very concerned about being able to pay for health care when their plan withdrew from the Medicare program. A similar, but not entirely overlapping, proportion of beneficiaries were also concerned about getting care while concerns about having to change providers were not quite as widespread but still considerable. Again, the more vulnerable subgroups, including the disabled, less-educated, people in the all other racial group (other than White non-Hispanic) or Hispanic, and those in fair or poor health, were disproportionately affected. Beneficiaries in non-metropolitan areas with low Medicare managed care penetration were also more concerned by the plan withdrawals. Having enough information reduced but did not eliminate the psychological impact of plan withdrawals.

The financial impact of plan withdrawals affected just over half of beneficiaries with higher premiums. However, as noted earlier in the report, the average monthly premiums increased for all Medicare+Choice enrollees along with increases in co-payments and reductions in benefits. However, for the involuntary disenrollees, higher premiums were more likely to come from acquiring supplemental insurance than from higher premiums due to enrollment in another HMO. Consequently, those in the more vulnerable subgroups were less likely to report paying more since they were less likely to have supplemental coverage. It is therefore likely that in the tradeoff between higher premiums versus lower benefits, the vulnerable were forced by circumstance to go with lower benefits. In an effort to keep our survey to a manageable length for respondents and due to the known unreliability of reports of specific benefit details, the only specific benefit about which beneficiaries reported was prescription drug coverage. About one in five beneficiaries lost prescription drug coverage as a result of their plan withdrawal. The disabled and those in fair to poor health were again impacted more than others by having to pay more for prescription medicines. Those in areas without a choice of another HMO were less likely to report having prescription drug coverage than those in areas with at least one HMO option.

Disruptions in provider arrangements were less widespread than some of the other outcomes of the plan withdrawals: only one in five beneficiaries indicated that they had had to change their personal doctor or nurse after their plan withdrew from Medicare. This was similar to the rate found in the Kaiser Family Foundation study. One out of ten total beneficiaries had to stop seeing a specialist (somewhat lower than the rate found in the Kaiser study). Although the rate of disruption was not as high as might have been predicted, there were significant differences within the involuntary disenrollee population. Those in areas with a choice of another HMO were more likely to report having to change their personal doctor or nurse than those without another HMO option. Among those who were seeing a specialist when their plan withdrew, the disabled and those in fair or poor health were more likely to have to stop seeing their specialist. As would be expected, the potential for disruption in provider arrangements was a tradeoff that beneficiaries

had to deal with in exchange for HMO coverage and the potential for more comprehensive benefits. Those who did not enroll in a different HMO were less likely to have to change providers.

In terms of access to care, one in ten beneficiaries who needed care after their plan withdrew indicated that they had trouble getting care. However, one in five beneficiaries delayed seeking care because of being worried about the cost and 15% did not get medicines that had been prescribed for them. This rate was three times higher than the rate found in the Kaiser study reflecting, perhaps, the increasing concerns about the costs of prescription medicines. Again, it was the disabled, people in the all other racial group or Hispanic, and those in fair to poor health whose access to care was most affected.

Clearly, the withdrawal of plans from the Medicare program affected large numbers of beneficiaries psychologically, financially, and/or in terms of their health care. However, what is of continuing concern is the disproportionate effect of these withdrawals on the most vulnerable. While HMOs that have managed to stay in the Medicare market may continue to offer beneficiaries an attractive alternative to Original Medicare, if and when the plans leave Medicare, thousands of disabled, minority, less educated, and sick beneficiaries are left uncertain about their options, worried about costs (particularly of prescription medicines), and less likely to get needed care. One strategy that appears to ameliorate some but not all of these problems is the provision of information about what will happen when a plan leaves and what, if any, options are available. However, the beneficiaries most likely to report they did not have enough information were those with the least education, the very old and the disabled, i.e. the beneficiaries who are probably least able to process additional information. Consequently, the problem may not have been a *lack* of information, but either too much information or information that they found to be confusing. Giving more information in the future without simplifying it may actually be counterproductive. Consequently, rather than simply providing more information, descriptions of the implications of plan withdrawals and the resulting options for coverage should be tailored to meet the specific needs of these vulnerable subgroups.

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Appendix A: Data Collection Activities

Data Collection Activities
2001 Survey of Medicare Beneficiaries Who Involuntarily Disenroll From Their Health Plans

The 2001 Survey of Medicare Beneficiaries Who Involuntarily Disenroll From Their Health Plans was conducted as a mail survey with telephone follow-up with mail survey nonrespondents. The mail survey consisted of the following:

- A pre-notification letter was sent to all sample members. This letter described the sponsorship and purpose of the survey, contained informed consent statements, and alerted sample members that they would receive the survey questionnaire in about a week.

- An initial questionnaire package, which contained a cover letter, the questionnaire, and a pre-addressed, postage-paid return envelope was sent to all sample members approximately twelve days after the pre-notification letter was mailed. This package included a help sheet listing all of the "product names" by which the sample health plan could be known, and a brochure that contained Frequently Asked Questions and answers to those questions. A Spanish request postcard was also included for sample members who wished to receive a copy of the questionnaire in Spanish.

- A thank you/reminder postcard, which was sent to all sample members seven days after the initial questionnaire package was mailed. The purpose of this card was to thank sample members who had already completed and returned the questionnaire, and to remind sample members who had not to do so at their earliest convenience.

- A second questionnaire package was sent to all sample members who **did not return** a completed questionnaire to RTI within four weeks of the initial questionnaire mailing. The second questionnaire was accompanied by a cover letter that contained a stronger appeal for the sample member's help with the survey, and also contained a pre-addressed, postage-paid envelope.

- A third questionnaire, which was mailed to all sample members who had not returned a completed questionnaire to RTI within three weeks after the *second* questionnaire package was mailed and for whom a telephone number could not be obtained. The third questionnaire package was sent by U.S. Priority Mail and contained a cover letter making a special appeal to sample members, as well as a pre-addressed, postage-paid envelope.

Sample members were given the option in the pre-notification letter to request a telephone interview or to complete and return the mail survey questionnaire. Telephone interviews were also conducted as a follow-up for non-respondents to the mail survey. Since CMS was not able to provide telephone numbers for Medicare beneficiaries, it was necessary to conduct tracing activities prior to starting the telephone follow-up of non-respondents. We used a combination of three sources to obtain a current telephone number for the sample members, including a commercial telephone number look-up service, calls to directory assistance, and various electronic databases. RTI's in-house Tracing Operations Unit conducted more extended tracing for a telephone number for a sample member if one was not provided by a commercial telephone number look-up service. The questionnaires used in the telephone follow-up interviews mirrored the mail survey questionnaires as closely as possible. Interviews were conducted using a computer-assisted telephone interviewing (CATI) program. An extensive quality control program was conducted on all data collection and processing activities to ensure the quality of the data collected.

Appendix B: Non-Response Analysis

Non-Response Analysis
2001 Survey of Medicare Beneficiaries Who Involuntarily Disenroll From Their Health Plans

Analyzing raw survey data can lead to misleading conclusions when adjustments for non-response are not taken into account. One of the common problems with raw, unweighted statistics is that it assumes that the responses of nonrespondents (had they been obtained) occur proportionally across all sub-groups. If this assumption is violated and if the responses of the affected subgroup are different than another (e.g. males respond differently than females), then differential non-response can occur.

One method for addressing differential non-response bias is to use logistic regression to model the functional relationship between a set of predictors and a dichotomous response outcome and then use that model to construct response propensity weights (Folsom 1991). If the relationship is significant, the model-based adjustment factors that are applied to the sampling weights greatly reduce the potential for non-response bias attributable to the response predictors.

Although response propensity modeling provides a formal statistical methodology for exploring factors related to a response, one should be careful when interpreting the results from these models. To construct such models, data are needed for respondents and non-respondents. When data on the non-respondents are limited, it is possible that some predictor variables are confounded or intercorrelated with other factors that are not in the model. The predictor variable then can achieve statistical significance by acting as a surrogate. For instance, in the Medicare population a person's age could conceivably be a surrogate for their health status.

The response propensity model used in this survey was defined as:

$$Y_i = \begin{cases} 1, \text{if beneficiary completes a survey} \\ 0, \text{otherwise} \end{cases}$$

Then we developed and used the following logistic model to estimate the probability that the beneficiary responded,

$$\begin{aligned} \hat{\gamma}_i = \quad & P[Y_i = 1 \mid X_i, \hat{\beta}] \\ & = [1 + \exp(-X_i \hat{\beta})]^{-1} \end{aligned}$$

where X_i is a vector of predictor variables.

This model based approach allowed us to *jointly* examine the relationship between obtaining a response and another set of predictor variables. As mentioned above, when conducting non-response analysis, the key is to have predictor data on the respondents *and* non-respondents. For this project, we had

several variables available on Medicare beneficiaries in each of the three stratum —age, race, sex, geographic information, hospice & dually eligible data.

We mined the address fields to create several indicator variables. Although every beneficiary is bound to have a different street and house number, there can be important information embedded within the address fields. For instance, the first line might read "Livingston HCC *for* John Doe", "John Doe *in care of* Jane Doe", or "Careview Rest *Home*". These particular fields may indicate a person in poor health that requires the care of another individual. We developed a computer program to identify these fields looking for certain key words and then created the following indicator variable.

$$X_i = \begin{cases} 1, \text{the key word or phrase was present in one of the address fields} \\ 0, \text{no occurance of the phrase in any field} \end{cases}$$

We created postal address indicator variables, including apartments, rural routes, Post Office boxes, and addresses that suggested a person is receiving care from others or that someone takes care of his/her affairs, and non-standard address length—both exceptionally long and short. Finally, we classified the addresses into the nine U.S. Census Bureau Divisions to check for regional effects.

We used a backwards step-wise method in this analysis. The initial model contained all main effects along with two-way interactions. Variables with p-values greater than 0.20 were then identified and the least significant variable was removed. The model was then recreated without that variable. We reiterated this process until effects with p-values less than or equal to 0.20 remained. The only exception to this rule was for design variables. Design variables were retained regardless of their p-value.

The final model contained six main effects and no interactions—race, age, three address/ geographic variables, and the design variable that was insignificant. The variables included within the response propensity model with degrees of freedom, odds ratios, and the p-values from the Wald F statistic for significance are shown in ***Table B1.***

This table is the result of a model that examines many factors simultaneously. Consequently, it is not uncommon to see "discrepancies" between model-based results and results generated when looking at factors univariately (i.e. one at a time). For example, the response propensity of beneficiaries with ESRD appears higher in the model than that of non-ESRD beneficiaries. However, the p-value for the group variable is insignificant implying that, once other variables were accounted for, the ESRD group did not have a statistically higher response propensity than the other groups. Most likely there are other term(s) in the model that are now acting as a surrogate for poor health (universally across all sample members). Consequently caution is advised in making any type of inference from non-response models. The data are usually quite limited and so it is very difficult to discriminate between actual effects and surrogate effects.

Table B1: Variables included within response propensity model with degrees of freedom, odds ratios, and p-values from Wald F statistic for significance.

Variable	Degrees of Freedom	Odds Ratio	P-value of Wald F
Group (design variable)	2		0.6004[1]
Orphans to ESRD		0.88	
Non-orphans to ESRD		1.16	
Race	2		<0.0001
African-American to Caucasian		0.44	
Other minorities to Caucasian		0.47	
Age Over 65 (10-year increments)	1	0.79	0.0033
Rural Route or P.O. Box	1	0.63	0.0115
Abnormally short or long addresses	1	1.43	0.0120
U.S. Census Divisions	8		0.1451[2]
New England to Pacific		1.13	
Middle Atlantic to Pacific		0.81	
East North Central to Pacific		0.60	
West North Central to Pacific		0.88	
South Atlantic to Pacific		0.86	
East South Central to Pacific		0.75	
West South Central to Pacific		0.64	
Mountain to Pacific		0.58	

[1]Design variables are retained regardless of p-values.

[2]Although this variable is not statistically significant at the 0.05 level, it does contribute to the fit of the model.

African-American and other minority races had less than half the odds of a response than did Caucasians. In fact, this was the most significant effect in the model. Age was also a significant factor. The odds of a response steadily decreased with the age of the sample member. No change in odds was noted in the under-65 population. A number of transformations and truncations were examined, but the one that explained the most variability was:

$$Age^*_i = \begin{cases} \dfrac{\text{age} - 65}{10}, & \text{if the sample member was 65 or over} \\ 0, & \text{otherwise} \end{cases}$$

This transformation created a quasi-continuous variable where 1-unit increments correspond to 10-year increments past the age of 65. Disenrollees under 65 have a value of 0.

Address fields that contained "rural routes" or "P.O. Boxes" (along with variant abbreviations) had a lower odds of response. Address fields that were abnormally short or long had a higher odds of response. As noted earlier, abnormally long addresses often suggest that an individual is in the care of someone else

which, in this case, may have increased the likelihood of response. Responses varied slightly among the U.S. Census Divisions. The New England Division (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont) appeared to have the greatest odds of response while the Mountain Division had the lowest (Arizona, Colorado, Idaho, New Mexico, Montana, Utah, Nevada, Wyoming). The confidence intervals for the odds ratios often encompassed one implying the results are not statistically different. But their inclusion does improve the fit of the overall model slightly.

Appendix C: Tables of Results

Table C.1
Sample strata by beneficiary characteristics

	Medicare HMO Available	No Medicare HMO Available	ESRD	Total
Unweighted base	n=2215	n=1195	n=370	n=3780
Age				
Under 65 years	7%	7%	16%	7%
65-74 years	52%	55%	46%	53%
75-84 years	33%	31%	34%	33%
85 years or more	7%	7%	5%	7%
Sex				
Female	58%	54%	44%	57%
Male	42%	46%	56%	43%
Race/Ethnicity				
White non-Hispanic	84%	84%	61%	84%
African-American	10%	7%	25%	9%
Hispanic	4%	8%	11%	5%
Other	2%	1%	2%	2%
Education				
Less than 9th grade	12%	18%	19%	13%
Some high school	18%	17%	27%	18%
High school graduate	36%	37%	29%	36%
Beyond high school	34%	28%	25%	33%
Self-reported health status				
Excellent	6%	5%	2%	6%
Very good	22%	19%	6%	22%
Good	37%	38%	21%	37%
Fair	28%	29%	41%	28%
Poor	7%	10%	30%	8%
Patient in hospital overnight or longer				
Yes	21%	21%	69%	21%
No or missing	79%	79%	31%	79%
Location				
Metropolitan county	97%	66%	95%	92%
Non-metropolitan county	3%	34%	5%	8%
Dual eligibility status				
Not Medicaid eligible	97%	96%	90%	97%
Medicaid eligible	3%	4%	10%	3%

NOTES: Percentages are based on weighted data. Sections within columns may not sum to 100 due to rounding. Metropolitan/non-metropolitan county designation based on the Office of Management and Budget (OMB) 1993 definition.

SOURCE: Survey of Involuntary Disenrollees 2001, CMS Enrollment Data Base.

Table C.2
Sample strata by beneficiary reports of information about plan withdrawals and new coverage

	Medicare HMO Available	No Medicare HMO Available	ESRD	Total
Unweighted base	n=2215	n=1195	n=370	n=3780
First found out that plan would stop coverage				
From plan itself	66%	66%	66%	66%
From newspaper, radio or TV	18%	19%	16%	18%
From doctor or other health care provider	6%	4%	9%	6%
From friend or relative	4%	5%	3%	4%
From current or former employer	1%	1%	1%	1%
From Medicare program	2%	1%	3%	2%
From other sources	0%	0%	1%	0%
Don't know	1%	0%	0%	1%
Missing or unable to code	2%	4%	2%	3%
Received letter from Plan				
Yes	95%	96%	96%	96%
No	2%	1%	2%	2%
Don't know or missing	2%	2%	2%	2%
Received enough information about options				
Yes	63%	61%	55%	63%
No	34%	36%	43%	35%
Don't know or missing	3%	2%	2%	3%

NOTES: Percentages are based on weighted data. Sections within columns may not sum to 100 due to rounding.

SOURCE: Survey of Involuntary Disenrollees 2001

Table C.3
First source of information about plan withdrawal by beneficiary characteristics

	From plan itself	From doctor or other provider	From family or friend	From TV, radio or newspaper	From all other sources[1]
Unweighted base	n=2440	n=216	n=163	n=715	n=236
All beneficiaries	66%	6%	4%	18%	6%
Age					
Under 65 years	61%	10%	4%	20%	6%
65-74 years	63%	6%	4%	21%	6%
75-84 years	70%	5%	4%	15%	7%
85 years or over	66%	5%	6%	17%	7%
Sex					
Female	67%	6%	3%	18%	6%
Male	65%	6%	5%	19%	6%
Education					
Less than 9th grade	70%	7%	6%	12%	5%
Some high school	72%	5%	4%	14%	5%
High school graduate	64%	5%	4%	20%	7%
More than high school	62%	6%	4%	23%	7%
Race/ethnicity					
White non-Hispanic	73%	8%	5%	20%	6%
All other racial groups and Hispanic	64%	5%	4%	8%	6%
Patient in hospital overnight or longer					
Yes	66%	9%	3%	16%	7%
No or missing	66%	6%	4%	18%	6%
Self-reported health status					
Poor or fair	66%	7%	5%	15%	7%
Good to excellent	66%	5%	4%	20%	6%
End Stage Renal Disease					
ESRD	66%	9%	3%	16%	7%
Non-ESRD	66%	6%	4%	18%	6%
Location					
Metropolitan county	65%	6%	4%	19%	6%
Non-metropolitan county	70%	3%	4%	17%	6%
Dual eligibility status					
Not Medicaid eligible	66%	5%	4%	19%	6%
Medicaid eligible	63%	9%	9%	11%	9%

[1] Includes those who did not answer the question and those who did not know their first source of information.

NOTES: Percentages are based on weighted data. Rows may not sum to 100 due to rounding.
Metropolitan/non-metropolitan county designation is based on the Office of Management and Budget (OMB) 1993 definition.

SOURCE: Survey of Involuntary Disenrollees 2001

Indicates chi-square significant at .01 level and percentage difference of at least 10%

Table C.4
Sample strata by beneficiary understanding of available options

	Medicare HMO Available	No Medicare HMO Available	ESRD	Total
Unweighted base	n=2215	n=1195	n=370	n=3780
Another Medicare HMO available				
Yes	52%	17%	29%	46%
No	20%	50%	41%	25%
Don't know or missing	28%	33%	30%	29%
Supplemental insurance plan available				
Yes	68%	69%	67%	68%
No	10%	16%	18%	11%
Don't know or missing	22%	15%	15%	21%
What did they think would happen when the plan stopped covering them				
Covered by Original Medicare	48%	50%	44%	48%
Able to select a new plan	3%	1%	2%	2%
Obtain coverage through employer	2%	2%	1%	2%
Have to purchase supplemental insurance	1%	1%	0%	1%
End up with no health insurance	28%	30%	27%	28%
Automatically enrolled in another HMO	8%	5%	10%	7%
Still stay in same insurance plan	2%	1%	2%	2%
Don't know	6%	5%	8%	6%
Missing or unable to code	5%	5%	6%	5%

NOTES: Percentages are based on weighted data. Sections within columns may not sum to 100 due to rounding.

SOURCE: Survey of Involuntary Disenrollees 2001

Table C.5
Beneficiaries' reports of adequacy of information and availability of supplemental insurance and understanding of implications of plan withdrawal by beneficiary characteristics

	Percentage Reporting		Percentage who understood what would happen when their plan withdrew[1]
	Enough Information	Supplemental Insurance Option Available	
Unweighted base	n=3780	n=3780	n=3780
All Beneficiaries	63%	68%	53%
Age			
Under 65 years	46%	51%	55%
65-74 years	64%	71%	55%
75-84 years	65%	70%	50%
85 years or over	59%	61%	46%
Race/ethnicity			
White non-Hispanic	65%	72%	56%
African American	48%	44%	39%
Hispanic	56%	53%	34%
Other	60%	65%	35%
Education			
Less than 9th grade	56%	55%	39%
Some high school	60%	62%	40%
High school graduate	65%	71%	55%
Beyond high school	65%	75%	63%
Self-reported health status			
Excellent	63%	62%	45%
Very good	67%	73%	57%
Good	66%	72%	54%
Fair	59%	63%	51%
Poor	49%	61%	47%
End Stage Renal Disease			
No	63%	68%	53%
Yes	55%	67%	47%
Adequacy of information about plan withdrawal			
Received enough information		77%	58%
Did not receive enough information		54%	45%

[1] Percentage of beneficiaries who thought they would be covered by the Original Medicare plan, covered through their current or former employer, would be able to select a new plan, or would have to purchase supplemental insurance.

NOTES: Percentages are based on weighted data.

SOURCE: Survey of Involuntary Disenrollees 2001

Indicates chi-square significant at .01 level and percentage difference of at least 10%

Table C.6
Sample strata by beneficiary reports about choosing new coverage

	Medicare HMO Available	No Medicare HMO Available	ESRD	Total
Unweighted base	n=2215	n=1195	n=370	n=3780
Satisfaction with time to choose new insurance				
Not at all satisfied	15%	16%	22%	15%
Not very satisfied	17%	15%	18%	17%
Somewhat satisfied	37%	36%	36%	37%
Very satisfied	26%	28%	20%	26%
Extremely satisfied	3%	4%	1%	3%
Don't know or missing	3%	2%	2%	2%
Who makes decisions about health insurance				
Beneficiary alone	56%	50%	32%	55%
With family/friend/insurance counselor	38%	44%	62%	39%
Someone else makes decision	5%	4%	5%	5%
Don't know or missing	1%	1%	2%	1%

NOTES: Percentages are based on weighted data. Sections within columns may not sum to 100 due to rounding.

SOURCE: Survey of Involuntary Disenrollees 2001

Table C.7
Sample strata by beneficiary reports of new coverage arrangements

	Medicare HMO Available	No Medicare HMO Available	ESRD	Total
Unweighted base	n=2215	n=1195	n=370	n=3780
Enrolled in Medicare HMO	56%	34%	37%	52%
Covered by Medicaid	3%	4%	11%	3%
Covered through current or former employer	8%	9%	7%	8%
Have supplemental insurance	19%	35%	34%	22%
Covered by Original Medicare Only	15%	18%	11%	15%

NOTES: Percentages are based on weighted data. Columns may not sum to 100 due to rounding. Respondents could indicate coverage under more than one arrangement so a hierarchical approach was used to assign them to the types of coverage. If respondents reported enrollment in a Medicare HMO, they were assigned to this category. For the remaining respondents (those who did not report enrollment in an HMO), if they reported that Medicaid covered them, they were assigned to this category. This process was repeated for each category so that the final category represented all respondents who did *not* report that they were enrolled in a Medicare HMO, were covered by Medicaid, were covered through a current or former employer, or had supplemental insurance. Thus, we designated these respondents as covered by Original Medicare only.

SOURCE: Survey of Involuntary Disenrollees 2001

Table C.8
Beneficiaries' reports of new coverage arrangements by beneficiary characteristics

		Percentage of All Beneficiaries Reporting		
		Enrolled in HMO Now	Have Supplemental Insurance	Enrolled in Original Medicare Only
All Beneficiaries		52%	56%	15%
Age Group	Under 65 years	47%	36%	32%
	65-74 years	52%	57%	14%
	75-84 years	51%	59%	14%
	85 years or over	61%	47%	13%
Gender	Male	50%	56%	17%
	Female	54%	56%	14%
Education	Less than 9th grade	50%	45%	22%
	Some high school	53%	55%	15%
	High school graduate	53%	59%	14%
	Beyond high school	52%	57%	12%
Race/ethnicity	White non-Hispanic	53%	60%	13%
	All other racial groups and Hispanic	50%	35%	27%
Hospitalized in past 12 months	Yes	53%	55%	13%
	No	52%	56%	16%
Self-reported health	Poor or fair	49%	50%	21%
	Good, very good, or excellent	54%	59%	12%
End Stage Renal Disease (ESRD)	ESRD	37%	70%	11%
	Non-ESRD	52%	56%	15%
Type of county	Metropolitan	53%	55%	15%
	Non-metropolitan	37%	69%	18%

NOTES: Percentages are based on weighted data.
Metropolitan/non-metropolitan county designation based on the Office of Management and Budget (OMB) 1993 definition.

SOURCE: Survey of Involuntary Disenrollees 2001

Indicates chi-square significant at .01 level and percentage difference of at least 10%

Table C.9
Sample strata by reasons cited by beneficiaries with Medicare only for not having supplemental insurance

	Medicare HMO Available	No Medicare HMO Available	ESRD	Total
Unweighted base[1]	n=249	n=183	n=28	n=460
Costs too much	66%	79%	27%	69%
Don't need it	8%	4%	0%	7%
Could not find policy with benefits needed	6%	4%	11%	5%
Applied and turned down/not accepted yet	4%	3%	18%	4%
Did not apply or thought they would be turned down	4%	2%	25%	4%
Not available in area/Not familiar with supplemental options	3%	1%	7%	3%
Don't know, missing or unable to code	10%	7%	11%	9%

[1] Includes only beneficiaries who indicated "No" to the question "Do you have supplemental health insurance now?"

NOTES: Percentages are based on weighted data. Columns may not sum to 100 due to rounding.

SOURCE: Survey of Involuntary Disenrollees 2001

Table C.10
Beneficiaries' satisfaction with new coverage

	Medicare HMO Available	No Medicare HMO Available	ESRD	Total
Unweighted base	n=2215	n=1195	n=370	n=3780
Satisfaction with health insurance now				
Less satisfied now	36.7%	40.2%	36.2%	37.3%
About the same now	39.4%	29.7%	33.6%	37.7%
More satisfied now	16.5%	19.3%	24.0%	17.0%
Don't know or missing	7.5%	10.8%	6.2%	8.0%

NOTES: Percentages are based on weighted data. Sections within columns may not sum to 100 due to rounding.

SOURCE: Survey of Involuntary Disenrollees 2001

Table C.11
Beneficiaries' satisfaction with new coverage by beneficiary characteristics

		Percentage reporting less satisfied with health insurance after plan withdrawal
Unweighted base		n=3780
All Beneficiaries		37%
Age Group	Under 65 years	53%
	65-74 years	39%
	75-84 years	33%
	85 years or over	27%
Gender	Male	37%
	Female	37%
Education	Less than 9th grade	35%
	Some high school	36%
	High school graduate	36%
	Beyond high school	40%
Race/Ethnicity	White non-Hispanic	37%
	All other racial groups and Hispanic	37%
Hospitalized in past 12 months	Yes	41%
	No	36%
Self-Reported Health	Poor or fair	42%
	Good, very good, or excellent	35%
End Stage Renal Disease	ESRD	36%
	Non-ESRD	37%
Type of County	Metropolitan	37%
	Non-metropolitan	40%
New coverage arrangements	Medicare HMO	34%
	Covered under Medicaid	30%
	Employer-provided	37%
	Supplemental	40%
	Original Medicare only	47%

NOTES: Percentages are based on weighted data.
Metropolitan/non-metropolitan county designation based on the Office of Management and Budget (OMB) 1993 definition.

SOURCE: Survey of Involuntary Disenrollees 2001

Indicates chi-square significant at .01 level and percentage difference of at least 10%

Table C.12
Sample strata by beneficiaries' reports about concerns about plan withdrawals

	Medicare HMO Available	No Medicare HMO Available	ESRD	Total
Unweighted base	n=2215	n=1195	n=370	n=3780
Concern about having to change personal doctor or nurse				
Not at all concerned	19%	30%	18%	21%
A little concerned	12%	13%	14%	12%
Somewhat concerned	15%	16%	17%	15%
Very concerned	50%	37%	48%	47%
Don't know or missing	2%	2%	2%	2%
Do not have personal doctor or nurse	3%	3%	1%	3%
Concern about no longer being able to pay for health care				
Not at all concerned	11%	11%	6%	11%
A little concerned	15%	14%	9%	15%
Somewhat concerned	21%	21%	15%	21%
Very concerned	50%	52%	68%	50%
Don't know or missing	3%	2%	3%	3%
Concern about not being able to get health care needed				
Not at all concerned	13%	13%	6%	13%
A little concerned	16%	15%	11%	15%
Somewhat concerned	19%	20%	13%	19%
Very concerned	49%	51%	68%	50%
Don't know or missing	2%	2%	2%	2%

NOTES: Percentages are based on weighted data. Sections within columns may not sum to 100 due to rounding.

SOURCE: Survey of Involuntary Disenrollees 2001

Table C.13
Beneficiaries' concerns about plan withdrawals by beneficiary characteristics

		Percentage Reporting Being		
		Very Concerned About Changing Provider	Very Concerned About Paying for Care	Very Concerned About Getting Care
Unweighted base		n=3615	n=3692	n=3702
All Beneficiaries		49%	52%	51%
Age Group	Under 65 years	70%	78%	79%
	65-74 years	50%	51%	49%
	75-84 years	44%	49%	48%
	85 years or over	45%	46%	48%
Gender	Male	47%	49%	47%
	Female	51%	54%	53%
Education	Less than 9th grade	55%	66%	64%
	Some high school	50%	62%	59%
	High school graduate	49%	51%	51%
	Beyond high school	47%	40%	40%
Race/Ethnicity	White non-Hispanic	47%	49%	48%
	All other racial groups and Hispanic	61%	68%	68%
Hospitalized in past 12 months	Yes	53%	59%	58%
	No	49%	50%	49%
Self-reported Health	Poor or fair	55%	65%	63%
	Good, very good, or excellent	46%	44%	44%
End Stage Renal Disease	ESRD	50%	70%	69%
	Non-ESRD	50%	52%	51%
Type of County	Metropolitan	50%	51%	50%
	Non-metropolitan	41%	57%	56%
New coverage arrangements	Medicare HMO	54%	52%	52%
	Covered under Medicaid	56%	65%	64%
	Employer-provided	35%	32%	31%
	Supplemental	41%	46%	41%
	Original Medicare only	53%	68%	69%

NOTES: Percentages are based on weighted data.
Metropolitan/non-metropolitan county designation based on the Office of Management and Budget (OMB) 1993 definition.

SOURCE: Survey of Involuntary Disenrollees 2001

Indicates chi-square significant at .01 level and percentage difference of at least 10%

Table C.14
Sample strata by beneficiaries' reports of financial implications of plan withdrawal

	Medicare HMO Available	No Medicare HMO Available	ESRD	Total
Unweighted base	n=2215	n=1195	n=370	n=3780
Payments for monthly premiums				
Pay more now	54%	63%	57%	56%
Pay same amount now	13%	10%	13%	13%
Pay less now	8%	6%	9%	8%
Don't pay premiums[1]	14%	9%	9%	13%
Don't know or missing	11%	11%	13%	11%
Former plan paid cost of medicines				
Yes	76%	65%	75%	74%
No	14%	23%	14%	16%
Don't know or missing	10%	12%	11%	10%
Health insurance now pays cost of medicine				
Yes	55%	41%	42%	53%
No	36%	49%	49%	38%
Don't know or missing	9%	11%	10%	10%
Paying for prescription medicines				
Pay more now	52%	49%	55%	51%
Pay same amount now	25%	25%	18%	25%
Pay less now	10%	10%	17%	10%
Don't know or missing	14%	16%	10%	14%

[1] Beneficiaries who paid no premiums both before and after plan withdrawal.

NOTES: Percentages are based on weighted data. Sections within columns may not sum to 100 due to rounding.

SOURCE: Survey of Involuntary Disenrollees 2001

Table C.15
Beneficiaries' reports of financial implications of plan withdrawals by beneficiary characteristics

		Percentage Reporting Having to	
		Pay more for premiums	Pay more for prescription drugs
Unweighted base		n=3780	n=3780
All Beneficiaries		56%	48%
Age Group	Under 65 years	39%	64%
	65-74 years	57%	48%
	75-84 years	57%	45%
	85 years or over	51%	39%
Gender	Male	55%	45%
	Female	56%	50%
Education	Less than 9th grade	53%	43%
	Some high school	53%	46%
	High school graduate	57%	47%
	Beyond high school	57%	51%
Race/Ethnicity	White non-Hispanic	58%	48%
	All other racial groups and Hispanic	41%	47%
Hospitalized in past 12 months	Yes	58%	51%
	No	55%	47%
Self-Reported Health	Poor or fair	53%	54%
	Good, very good, or excellent	57%	44%
End Stage Renal Disease	ESRD	57%	52%
	Non-ESRD	55%	48%
Type of County	Metropolitan	55%	48%
	Non-metropolitan	66%	44%
New coverage arrangements	Medicare HMO	53%	43%
	Covered under Medicaid	35%	36%
	Employer-provided	50%	32%
	Supplemental	89%	63%
	Original Medicare only	21%	51%

NOTES: Percentages are based on weighted data.
Metropolitan/non-metropolitan county designation based on the Office of Management and Budget (OMB) 1993 definition.

SOURCE: Survey of Involuntary Disenrollees 2001

Indicates chi-square significant at .01 level and percentage difference of at least 10%

Table C.16
Sample strata by beneficiaries' reports of impact on provider arrangements

	Medicare HMO Available	No Medicare HMO Available	ESRD	Total
Unweighted base	n=2215	n=1195	n=370	n=3780
Had to change personal doctor or nurse				
Yes	22%	12%	15%	21%
No	70%	78%	75%	71%
Don't know or missing	5%	6%	8%	5%
Do not have personal doctor or nurse	3%	4%	3%	3%
Problem to get personal doctor or nurse[1]	n=478	n=144	n=56	n=678
A big problem	20%	13%	28%	19%
A small problem	26%	17%	21%	24%
Not a problem	45%	58%	40%	46%
Don't know or missing	5%	1%	6%	4%
Have not found a new doctor yet	6%	11%	5%	6%
Seeing a specialist in former plan	n=2215	n=1195	n=370	n=3780
Yes	41%	38%	79%	40%
No	55%	58%	16%	55%
Don't know or missing	4%	5%	6%	4%
Had to stop seeing specialist[2]	n=895	n=448	n=293	n=1636
Yes	24%	16%	9%	22%
No	66%	73%	81%	67%
Don't know or missing	8%	10%	9%	9%
Did not need to see a specialist	2%	2%	1%	2%

[1] Includes only beneficiaries who indicated "yes" to the question "When you changed from *nonrenewing plan* to the health insurance you have now, did you have to change your personal doctor or nurse?"

[2] Includes only beneficiaries who indicated "yes" to the question "During the last 6 months you were enrolled in *nonrenewing plan*, were you seeing a specialist on a regular basis?"

NOTES: Percentages are based on weighted data. Sections within columns may not sum to 100 due to rounding.

SOURCE: Survey of Involuntary Disenrollees 2001

Table C.17
Beneficiaries' reports of impact on provider arrangements by beneficiary characteristics

		Percentage Reporting	
		Had to Change Provider[1]	Had to Stop Seeing Specialist[2]
Unweighted base		n=3657	n=1603
Total		21%	23%
Age Group	Under 65 years	27%	39%
	65-74 years	21%	25%
	75-84 years	19%	15%
	85 years or over	23%	17%
Gender	Male	23%	24%
	Female	20%	23%
Education	Less than 9th grade	24%	22%
	Some high school	20%	22%
	High school graduate	20%	23%
	Beyond high school	22%	22%
Race/Ethnicity	White non-Hispanic	20%	20%
	All other racial groups and Hispanic	28%	31%
Hospitalized in past 12 months	Yes	22%	21%
	No	21%	24%
Self-Reported Health	Poor or fair	23%	25%
	Good, very good, or excellent	20%	21%
End Stage Renal Disease	ESRD	16%	9%
	Non-ESRD	21%	23%
Type of County	Metropolitan	22%	24%
	Non-metropolitan	10%	14%
New coverage arrangements	Medicare HMO	28%	28%
	Covered under Medicaid	17%	30%
	Employer-provided	11%	10%
	Supplemental	9%	9%
	Original Medicare only	19%	38%

[1] Excludes beneficiaries who indicated that "I do not have a personal doctor or nurse" in response to the question "When you changed from *nonrenewing plan* to the health insurance you have now, did you have to change your personal doctor or nurse?"

[2] Includes only beneficiaries who indicated "yes" to the question "During the last 6 months you were enrolled in *nonrenewing plan*, were you seeing a specialist on a regular basis?" (n=1636) and then excludes beneficiaries who indicated that "I did not need to see a specialist" in response to the question "Did you have to stop seeing your specialist?" (n=33)

NOTES: Percentages are based on weighted data.
Metropolitan/non-metropolitan county designation based on the Office of Management and Budget (OMB) 1993 definition.

SOURCE: Survey of Involuntary Disenrollees 2001

Indicates chi-square significant at .01 level and percentage difference of at least 10%

Table C.18
Sample strata by beneficiaries' reports of problems with access to care

	Medicare HMO Available	No Medicare HMO Available	ESRD	Total
Trouble getting health care they wanted or needed	n=2215	n=1195	n=370	n=3780
Yes	11%	10%	13%	11%
No	74%	74%	84%	74%
Don't know or missing	2%	2%	1%	2%
Did not try to get health care	13%	13%	3%	13%
Delayed seeking care because of cost	n=3780	n=1195	n=370	n=3780
Yes	21%	25%	21%	22%
No	68%	64%	75%	67%
Don't know or missing	2%	2%	3%	2%
Did not need medical care	10%	9%	2%	10%
Did not get prescribed medicines	n=3780	n=1195	n=370	n=3780
Yes	15%	13%	20%	15%
No	74%	76%	73%	75%
Don't know or missing	4%	4%	6%	4%
Did not need prescribed medicine	6%	6%	1%	6%
Main reason did not get prescribed medicine[1]	n=338	n=155	n=73	n=566
Costs too much	69%	84%	85%	71%
Insurance won't cover/Plan limited amount of prescription medicine	14%	4%	5%	13%
Didn't have way to get medicine	3%	4%	3%	3%
Didn't think medicine was necessary/Felt better and didn't need medicine	2%	1%	0%	2%
Don't like to take medicine	1%	1%	0%	1%
Unable to code/missing/don't know	10%	7%	7%	10%

[1] Includes only beneficiaries who indicated "yes" in response to the question "Since leaving *nonrenewing plan*, were any medicines prescribed for you that you did not get?"

NOTES: Percentages are based on weighted data. Sections within columns may not sum to 100 due to rounding.

SOURCE: Survey of Involuntary Disenrollees 2001

Table C.19
Beneficiaries' reports of problems with access to care by beneficiary characteristics

		Percentage Reporting		
		Trouble Getting Care[1]	Delaying Health Care Due to Cost[2]	Not Getting Prescribed Medicines[3]
Unweighted base		n=3321	n=3455	n=3566
All Beneficiaries		12%	24%	15%
Age Group	Under 65 years	33%	52%	39%
	65-74 years	13%	25%	14%
	75-84 years	9%	19%	13%
	85 years or over	7%	13%	8%
Gender	Male	12%	23%	13%
	Female	13%	25%	17%
Education	Less than 9th grade	14%	30%	16%
	Some high school	12%	27%	16%
	High school graduate	11%	23%	14%
	Beyond high school	13%	22%	15%
Race/Ethnicity	White	11%	22%	13%
	Non-white or Hispanic	22%	35%	23%
Hospitalized in past 12 arrangements	Yes	15%	26%	22%
	No	11%	24%	13%
Self-Reported Health	Poor or fair	17%	34%	23%
	Good, very good, or excellent	10%	19%	11%
End Stage Renal Disease	ESRD	13%	21%	20%
	Non-ESRD	12%	24%	15%
Type of County	Metropolitan	12%	24%	15%
	Non-metropolitan	13%	28%	15%
New coverage arrangements	Medicare HMO	11%	19%	15%
	Covered under Medicaid	15%	32%	15%
	Employer-provided	7%	13%	6%
	Supplemental	6%	21%	14%
	Original Medicare only	34%	55%	21%

[1] Excludes beneficiaries who indicated that they did not try to get any health care since leaving *nonrenewing plan.*

[2] Excludes beneficiaries who indicated that they did not need any health care since leaving *nonrenewing plan.*

[3] Excludes beneficiaries who indicated that they did not need any prescription medicines since leaving *nonrenewing plan.*

NOTES: Percentages are based on weighted data.
Metropolitan/non-metropolitan county designation based on the Office of Management and Budget (OMB) 1993 definition.

SOURCE: Survey of Involuntary Disenrollees 2001

Indicates chi-square significant at .01 level and percentage difference of at least 10%

Table C.20
Impact of plan withdrawals on care for End Stage Renal Disease (ESRD) beneficiaries

	ESRD
Unweighted base	n=370
Receiving dialysis treatments	
Yes	88%
No	9%
Don't know or missing	2%
Had to change dialysis locations	
Yes	3%
No	85%
Don't know or missing	12%
Had to change to new doctor for kidney disease	
Yes	6%
No	93%
Don't know or missing	1%

SOURCE: Survey of Involuntary Disenrollees 2001

Table C.21
Logistic regression of beneficiaries living in counties with choice of another HMO, who reported enrolling in another HMO after plan withdrawal

Independent Variables		Odds Ratio	95% Confidence Interval Lower Limit	95% Confidence Interval Upper Limit
Intercept		0.63	0.47	0.84
Age	Under 65 years (disabled)	0.92	0.61	1.40
	65 years or over	1.00	1.00	1.00
Gender	Female	1.16	0.94	1.42
	Male	1.00	1.00	1.00
Race/ethnicity	All other racial groups and Hispanic	1.03	0.76	1.39
	White non-Hispanic	1.00	1.00	1.00
Education	Less than 9th grade	1.04	0.75	1.45
	9th grade or more	1.00	1.00	1.00
Self-reported health	Poor to fair	0.85	0.67	1.07
	Good to excellent	1.00	1.00	1.00
Hospitalized in past 12 months	Yes	1.07	0.82	1.38
	No	1.00	1.00	1.00
CMS Region	Region 6	0.72	0.55	0.94
	Other regions	1.00	1.00	1.00
County	Non-metropolitan	1.59	0.83	3.07
	Metropolitan	1.00	1.00	1.00
Medicare Managed Care Market Penetration	High (35-45%)	6.58	4.15	10.43
	Moderate (15-34%)	3.91	2.99	5.12
	Limited (6-14%)	1.74	1.27	2.38
	Minimal (1-5%)	1.00	1.00	1.00
Medicare Payment Rate To M+C Organization	Monthly payment < $525	0.93	0.53	1.64
	Monthly payment = $525	0.70	0.54	0.90
	Monthly payment > $525	1.00	1.00	1.00
Information about plan withdrawal	Not enough information	0.81	0.65	1.01
	Enough information	1.00	1.00	1.00

NOTES: Initial sample size for this logistic regression is 2,215.
Model is significant. Cox & Snell R-Square for Dependent Variable Reporting HMO Enrollment = 0.10 (without Medicare Managed Market Penetration, this drops to 0.03).
Metropolitan/non-metropolitan county designation based on 1993 OMB definition.
Medicare Managed Care Market Penetration groups based on characterization of Medicare markets by the Center for Studying Health System Change.

SOURCE: Survey of Involuntary Disenrollees 2001, CMS files.

Highlighted values of odds ratios are significant at 95% probability level.

Table C.22
Logistic regression of beneficiaries in counties with choice of another HMO, who enrolled in a Medicare+Choice plan after plan withdrawal, according to CMS administrative records

Independent Variables		Odds Ratio	95% Confidence Interval	
			Lower Limit	Upper Limit
Intercept		0.17	0.12	0.26
Age	Under 65 years (disabled)	1.50	0.95	2.39
	65 years or over	1.00	1.00	1.00
Gender	Female	1.29	1.02	1.62
	Male	1.00	1.00	1.00
Race/ethnicity	All other racial groups and Hispanic	0.94	0.68	1.30
	White non-Hispanic	1.00	1.00	1.00
Education	Less than 9th grade	0.97	0.68	1.39
	9th grade or more	1.00	1.00	1.00
Self-reported health	Poor to fair	0.82	0.64	1.05
	Good to excellent	1.00	1.00	1.00
Hospitalized in past 12 months	Yes	0.95	0.72	1.25
	No	1.00	1.00	1.00
CMS Region	Region 6	0.88	0.65	1.17
	Other regions	1.00	1.00	1.00
County	Non-metropolitan	0.69	0.23	2.03
	Metropolitan	1.00	1.00	1.00
Medicare Managed Care Market Penetration	High (35-45%)	22.89	13.59	38.54
	Moderate (15-34%)	9.21	6.35	13.37
	Limited (6-14%)	3.25	2.12	4.99
	Minimal (1-5%)	1.00	1.00	1.00
Medicare Payment Rate To M+C Organization	Monthly payment < $525	0.35	0.14	0.83
	Monthly payment = $525	0.87	0.66	1.14
	Monthly payment > $525	1.00	1.00	1.00
Information about plan withdrawal	Not enough information	0.67	0.52	0.85
	Enough information	1.00	1.00	1.00

NOTES: Initial sample size for this logistic regression is 2,215. Model is significant. Cox & Snell R-Square for Dependent Variable HMO Enrollment According to Administrative Records = 0.20 (without Medicare Managed Market Penetration, this drops to 0.05).
Metropolitan/non-metropolitan county designation based on 1993 OMB definition.
Medicare Managed Care Market Penetration groups based on characterization of Medicare markets by the Center for Studying Health System Change.

SOURCE: Survey of Involuntary Disenrollees 2001, CMS files.

Highlighted values of odds ratios are significant at 95% probability level.

Table C.23
Logistic regression of beneficiaries reporting having supplemental insurance after plan withdrawal

Independent Variables		Odds Ratio	95% Confidence Interval	
			Lower Limit	Upper Limit
Intercept		3.33	2.42	4.59
Age	Under 65 years (disabled)	0.41	0.27	0.60
	65 years or over	1.00	1.00	1.00
Gender	Female	1.07	0.88	1.31
	Male	1.00	1.00	1.00
Race/ethnicity	All other racial groups and Hispanic	0.54	0.41	0.72
	White non-Hispanic	1.00	1.00	1.00
Education	Less than 9th grade	0.67	0.50	0.91
	9th grade or more	1.00	1.00	1.00
Self-reported health	Poor to fair	0.83	0.67	1.03
	Good to excellent	1.00	1.00	1.00
Hospitalized in past 12 months	Yes	1.15	0.89	1.47
	No	1.00	1.00	1.00
CMS Region	Region 6	0.58	0.45	0.74
	Other regions	1.00	1.00	1.00
County	Non-metropolitan	0.80	0.57	1.14
	Metropolitan	1.00	1.00	1.00
Reported HMO enrollment	Yes	0.70	0.57	0.85
	No	1.00	1.00	1.00
Reported enrollment in Medicaid	Yes	1.01	0.67	1.51
	No	1.00	1.00	1.00
Medicare Managed Care Market Penetration	High (35-45%)	0.38	0.24	0.58
	Moderate (15-34%)	0.62	0.47	0.82
	Limited (6-14%)	0.74	0.54	1.01
	Minimal (1-5%)	1.39	1.02	1.89
	None (no HMO available)	1.00	1.00	1.00
Medicare Payment Rate To M+C Organization	Monthly payment < $525	2.90	2.08	4.04
	Monthly payment = $525	1.52	1.19	1.93
	Monthly payment > $525	1.00	1.00	1.00
Information about plan withdrawal	Not enough information	0.84	0.69	1.03
	Enough information	1.00	1.00	1.00

NOTES: Overall sample size for this logistic regression is 3,780.
Model is significant. Cox & Snell R-Square for Dependent Variable Having Supplemental Insurance = 0.12
Metropolitan/non-metropolitan county designation based on the Office of Management and Budget (OMB) 1993 definition.
Medicare Managed Care Market Penetration groups based on characterization of Medicare markets by the Center for Studying Health System Change.

SOURCE: Survey of Involuntary Disenrollees 2001

Highlighted values of odds ratios are significant at 95% probability level.

Table C.24
Logistic regression of beneficiaries reporting having Medicare only after plan withdrawal

Independent Variables		Odds Ratio	95% Confidence Interval	
			Lower Limit	Upper Limit
Intercept	Intercept	0.15	0.10	0.22
Age	Under 65 years (disabled)	1.89	1.29	2.77
	65 years or over	1.00	1.00	1.00
Gender	Female	0.81	0.63	1.02
	Male	1.00	1.00	1.00
Race/ethnicity	All other racial groups and Hispanic	1.45	.07	1.98
	White non-Hispanic	1.00	1.00	1.00
Education	Less than 9th grade	1.36	0.98	1.89
	9th grade or more	1.00	1.00	1.00
Self-reported health	Poor to fair	1.58	1.22	2.05
	Good to excellent	1.00	1.00	1.00
Hospitalized in past 12 months	Yes	0.65	0.48	0.89
	No	1.00	1.00	1.00
CMS Region	Region 6	1.82	1.38	2.41
	Other regions	1.00	1.00	1.00
County	Non-metropolitan	1.42	0.96	2.11
	Metropolitan	1.00	1.00	1.00
Medicare Managed Care Market Penetration	High (35-45%)	0.44	0.22	0.86
	Moderate (15-34%)	0.46	0.32	0.67
	Limited (6-14%)	0.98	0.68	1.40
	Minimal (1-5%)	0.78	0.55	1.09
	None (no HMO available)	1.00	1.00	1.00
Medicare Payment Rate To M+C Organization	Monthly payment < $525	0.47	0.32	0.69
	Monthly payment = $525	0.91	0.66	1.25
	Monthly payment > $525	1.00	1.00	1.00
Information about plan withdrawal	Not enough information	1.61	1.26	2.06
	Enough information	1.00	1.00	1.00

NOTES: Initial sample size for this logistic regression is 3,780. Model is significant. Cox & Snell R-Square for Dependent Variable Having Medicare only = 0.07
Metropolitan/non-metropolitan county designation based on the Office of Management and Budget (OMB) 1993 definition.
Medicare Managed Care Market Penetration groups based on characterization of Medicare markets by the Center for Studying Health System Change.

SOURCE: Survey of Involuntary Disenrollees 2001

Highlighted values of odds ratios are significant at 95% probability level.

Table C.25
Logistic regression of beneficiaries reporting being very concerned about getting needed health care after plan withdrawal

Independent Variables		Odds Ratio	95% Confidence Interval	
			Lower Limit	Upper Limit
Intercept	Intercept	0.75	0.52	1.09
Age	Under 65 years (disabled)	2.30	1.53	3.47
	65 years or over	1.00	1.00	1.00
Gender	Female	1.37	1.14	1.64
	Male	1.00	1.00	1.00
Race/ethnicity	All other racial groups and Hispanic	1.66	1.26	2.18
	White non-Hispanic	1.00	1.00	1.00
Education	Less than 9th grade	1.55	1.17	2.04
	9th grade or more	1.00	1.00	1.00
Self-reported health	Poor to fair	1.56	1.29	1.89
	Good to excellent	1.00	1.00	1.00
Hospitalized in past 12 months	Yes	1.38	1.10	1.72
	No	1.00	1.00	1.00
CMS Region	Region 6	1.05	0.83	1.33
	Other regions	1.00	1.00	1.00
County	Non-metropolitan	1.42	1.01	2.00
	Metropolitan	1.00	1.00	1.00
New coverage arrangement	Medicare HMO	0.72	0.53	0.96
	Covered under Medicaid	0.75	0.44	1.28
	Employer-provided	0.31	0.21	0.47
	Supplemental	0.43	0.31	0.59
	Original Medicare only	1.00	1.00	1.00
Medicare Managed Care Market Penetration	High (35-45%)	0.69	0.46	1.05
	Moderate (15-34%)	0.74	0.57	0.96
	Limited (6-14%)	1.05	0.78	1.41
	Minimal (1-5%)	0.98	0.74	1.30
	None (no HMO available)	1.00	1.00	1.00
Medicare Payment Rate To M+C Organization	Monthly payment < $525	0.67	0.47	0.95
	Monthly payment = $525	0.89	0.72	1.12
	Monthly payment > $525	1.00	1.00	1.00
Information about plan withdrawal	Not enough information	2.55	2.11	3.07
	Enough information	1.00	1.00	1.00

NOTES: Initial sample size for this logistic regression is 3,780. Model is significant.
Cox & Snell R-Square for Dependent Variable Being Very Concerned About Getting Care =0.14
Metropolitan/non-metropolitan county designation based on the Office of Management and Budget (OMB) 1993 definition.
Medicare Managed Care Market Penetration groups based on characterization of Medicare markets by the Center for Studying Health System Change.

SOURCE: Survey of Involuntary Disenrollees 2001

Highlighted values of odds ratios are significant at 95% probability level.

Table C.26
Logistic regression of beneficiaries having to pay more versus paying the same or less for premiums after plan withdrawal

Independent Variables		Odds Ratio	95% Confidence Interval	
			Lower Limit	Upper Limit
Intercept	Intercept	11.73	7.32	18.78
Age	Under 65 years (disabled)	0.52	0.31	0.88
	65 years or over	1.00	1.00	1.00
Gender	Female	1.19	0.93	1.52
	Male	1.00	1.00	1.00
Race/ethnicity	All other racial groups and Hispanic	0.77	0.52	1.13
	White non-Hispanic	1.00	1.00	1.00
Education	Less than 9th grade	1.27	0.84	1.90
	9th grade or more	1.00	1.00	1.00
Self-reported health	Poor to fair	1.07	0.81	1.41
	Good to excellent	1.00	1.00	1.00
Hospitalized in past 12 months	Yes	1.30	0.95	1.76
	No	1.00	1.00	1.00
End Stage Renal Disease	Yes	0.86	0.56	1.34
	No	1.00	1.00	1.00
CMS region	Region 6	2.33	1.63	3.33
	Other regions	1.00	1.00	1.00
County	Non-metropolitan	0.79	0.47	1.33
	Metropolitan	1.00	1.00	1.00
New coverage arrangement	Supplemental	5.24	3.72	7.37
	Employer-provided	1.04	0.70	1.54
	Medicare HMO	1.00	1.00	1.00
Medicare managed care market penetration	High (35-45%)	0.44	0.26	0.73
	Moderate (15-34%)	0.55	0.39	0.77
	Limited (6-14%)	0.64	0.43	0.96
	Minimal (1-5%)	1.30	0.85	1.99
	None (no HMO available)	1.00	1.00	1.00
Medicare Payment Rate To M+C Organization	Monthly payment < $525	1.36	0.84	2.18
	Monthly payment = $525	0.88	0.65	1.19
	Monthly payment > $525	1.00	1.00	1.00

NOTES: Initial sample size for this logistic regression is 2,604 (excludes those with Medicare only, those with Medicaid coverage, and those who paid no premiums before and after plan withdrawal and those who did not know whether they paid higher or lower premiums). Model is significant. Cox & Snell R-Square for Dependent Variable For Having to Pay =0.13.
Metropolitan/non-metropolitan county designation based on the Office of Management and Budget (OMB) 1993 definition.
Medicare Managed Care Market Penetration groups based on characterization of Medicare markets by the Center for Studying Health System Change.

SOURCE: Survey of Involuntary Disenrollees 2001, CMS files.

Highlighted values of odds ratios are significant at 95% probability level.

Appendix D: Survey Instrument

A copy of the survey instrument for non-ESRD beneficiaries is provided on the next page. The questionnaire for ESRD beneficiaries was the same as the one for non-ESRD beneficiaries with the exception of three additional questions that were asked only of ESRD beneficiaries:

27. When [MEDICARE HEALTH PLAN NAME] stopped covering you, were you receiving dialysis treatments?

1 ☐ Yes

2 ☐ No → **Go to Question 29**

28. When you changed from [MEDICARE HEALTH PLAN NAME] to the health insurance you have now, did you have to change locations where you get your dialysis treatments?

1 ☐ Yes

2 ☐ No

29. When you changed from [MEDICARE HEALTH PLAN NAME] to the health insurance you have now, did you have to change to a new doctor to get treatment for your kidney disease?

1 ☐ Yes

2 ☐ No

OMB No. *0938-0817*
Expires 6/30/2001

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

Survey of Medicare Beneficiaries-A

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0817**. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data sources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

Instructions for Completing This Survey

Please read this before you begin . . . .

1. For **each** question:

   - Be sure to read **all** the answer choices listed before marking your answer.
   - Mark the box to the left of your answer, like this:

     ☒ Yes
     ☐ No
     ☐ Don't know

2. You will sometimes be instructed to skip some questions in this questionnaire. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

     ☐ Yes
     ☒ No ➜ **Go to Question 5**
     ☐ Don't know

   If there is no arrow with a note telling you where to go next, then continue with the next question.

3. Please mark only one answer in each question except for Question 35.

Please go to the top of the next page and begin with Question 1.

YOUR FORMER HEALTH INSURANCE

1. **Our records show that [MEDICARE HEALTH PLAN NAME] stopped covering you at the end of 2000. Is that right?**

   1 ☐ Yes → **Go to Question 2**

   2 ☐ No → **Do NOT answer the rest of these questions. Please return this survey in the postage-paid envelope. Thank you.**

   -4 ☐ Don't know → **Do NOT answer the rest of these questions. Please return this survey in the postage-paid envelope. Thank you.**

2. **If you needed <u>prescription medicines</u> when you were enrolled in [MEDICARE HEALTH PLAN NAME], would [MEDICARE HEALTH PLAN NAME] have paid any part of the cost of your medicines?**

   1 ☐ Yes

   2 ☐ No

   -4 ☐ Don't know

CHOOSING NEW HEALTH INSURANCE

This next set of questions asks about your experiences with choosing new health insurance.

3. **How did you <u>first</u> find out that [MEDICARE HEALTH PLAN NAME] was going to stop covering you? (Please mark only one answer.)**

   1 ☐ From [MEDICARE HEALTH PLAN NAME] itself

   2 ☐ From the Medicare program

   3 ☐ From a doctor or other health care provider

   4 ☐ From a friend or relative

   5 ☐ From a newspaper, radio, or TV

   6 ☐ Some other way (Please specify)

   _____

   _____

4. **Did you get a letter from [MEDICARE HEALTH PLAN NAME] telling you that it was going to stop covering you after December 31, 2000?**

   1 ☐ Yes

   2 ☐ No

   -4 ☐ Don't know

For the following questions, please think about what happened <u>after you found out that you would no longer be covered by [MEDICARE HEALTH PLAN NAME]</u>.

5. Did you get enough information about your health insurance options after you found out that you would no longer be covered by [MEDICARE HEALTH PLAN NAME]?

1 ☐ Yes

2 ☐ No

6. How satisfied are you with the amount of time you had to choose new health insurance?

1 ☐ Not at all satisfied

2 ☐ Not very satisfied

3 ☐ Somewhat satisfied

4 ☐ Very satisfied

5 ☐ Extremely satisfied

7. Who makes the decisions about which health insurance you get?

1 ☐ You alone make the decisions

2 ☐ You and a family member, friend, or insurance counselor make the decisions together

3 ☐ Someone else makes the decisions for you

8. Some people with Medicare have additional insurance to pay for health care and services that Medicare does not cover. This is called <u>supplemental or Medigap insurance</u>.

After you found out that you would no longer be covered by [MEDICARE HEALTH PLAN NAME], was there a supplemental health insurance plan available in your area?

1 ☐ Yes

2 ☐ No

-4 ☐ Don't know

9. Was there another Medicare HMO (also known as a managed care plan) available in your area?

1 ☐ Yes

2 ☐ No

-4 ☐ Don't know

10. What did you think would happen if you did not change your health insurance before December 31, 2000?

1 ☐ I thought I would automatically be enrolled in another Medicare HMO

2 ☐ I thought I would be covered by the Original Medicare plan (also known as fee-for-service or traditional Medicare)

3 ☐ I thought I could still stay in the same insurance plan

4 ☐ I thought I would end up with no health insurance

5 ☐ Other (Please specify)

_____

_____

-4 ☐ Don't know

For the next set of questions, please think about what you were feeling <u>after you found out that you would no longer be covered by [MEDICARE HEALTH PLAN NAME].</u>

11. A personal doctor or nurse is the health provider who knows you best. This can be a doctor, a nurse practitioner, or a physician assistant.

How concerned were you that you might have to change your personal doctor or nurse?

1 ☐ Not at all concerned

2 ☐ A little concerned

3 ☐ Somewhat concerned

4 ☐ Very concerned

-3 ☐ I do not have a personal doctor or nurse

12. How concerned were you that you would no longer be able to pay for your health care?

1 ☐ Not at all concerned

2 ☐ A little concerned

3 ☐ Somewhat concerned

4 ☐ Very concerned

13. **How concerned were you that you would no longer be able to get the health care you need?**

1 ☐ Not at all concerned

2 ☐ A little concerned

3 ☐ Somewhat concerned

4 ☐ Very concerned

YOUR CURRENT HEALTH INSURANCE

The questions in this section ask about the health insurance you have now.

14. **Are you enrolled in a Medicare HMO or managed care plan now?**

1 ☐ Yes

2 ☐ No

-4 ☐ Don't know

15. **Some people with Medicare are also covered by Medicaid, the state medical assistance program. Medicaid is run by your state to help some lower-income people pay for health care.**

Are you covered by Medicaid now?

1 ☐ Yes

2 ☐ No

-4 ☐ Don't know

16. **Do you have supplemental health insurance now?**

1 ☐ Yes → **Go to Question 18**

2 ☐ No

-3 ☐ I have not heard of this type of insurance → **Go to Question 18**

17. **What is the main reason you don't have supplemental health insurance? (Please mark only one answer.)**

1 ☐ I don't need supplemental insurance

2 ☐ I couldn't find a policy with the benefits I need

3 ☐ I applied and was turned down

4 ☐ I thought I would be turned down because of my health

5 ☐ It costs too much

6 ☐ Some other reason (Please specify)

_____

_____

18. **Do you get any of the health insurance you have now through your or your spouse's current or former employer or union?**

1 ☐ Yes

2 ☐ No

-4 ☐ Don't know

19. **How satisfied are you with the health insurance you have now compared to [MEDICARE HEALTH PLAN NAME]?**

- 1 ☐ Less satisfied now
- 2 ☐ About the same now
- 3 ☐ More satisfied now

20. **If you need <u>prescription medicines</u>, will the health insurance you have now pay any part of the cost of the medicines?**

- 1 ☐ Yes
- 2 ☐ No
- -4 ☐ Don't know

21. **Do you think you will pay more, less, or about the same now for <u>prescription medicines</u> as you did when you were enrolled in [MEDICARE HEALTH PLAN NAME]?**

- 1 ☐ I will pay more now
- 2 ☐ I will pay about the same amount now
- 3 ☐ I will pay less now
- -4 ☐ Don't know
- -3 ☐ I don't use prescription medicines

22. **Sometimes people have to pay a monthly insurance premium for a Medicare HMO or supplemental insurance. This is separate from the amount you pay for Medicare Part B, which is usually deducted from your Social Security check each month.**

Do you pay more, less, or about the same now for <u>monthly insurance premiums</u> as you did when you were enrolled in [MEDICARE HEALTH PLAN NAME]?

- 1 ☐ I pay more now
- 2 ☐ I pay about the same amount now
- 3 ☐ I pay less now
- -4 ☐ Don't know
- -3 ☐ I didn't pay a premium for [MEDICARE HEALTH PLAN NAME] and I don't pay a premium now

GETTING THE CARE YOU NEED

The questions in this section ask about your experiences with getting health care since you left [MEDICARE HEALTH PLAN NAME].

23. When you changed from [MEDICARE HEALTH PLAN NAME] to the health insurance you have now, did you have to change your personal doctor or nurse?

1 ☐ Yes

2 ☐ No → **Go to Question 25**

-3 ☐ I do not have a personal doctor or nurse

24. With the choices your current health insurance gave you, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?

1 ☐ A big problem

2 ☐ A small problem

3 ☐ Not a problem

-3 ☐ I have not found a new doctor yet

25. Specialists are doctors like surgeons, heart doctors, psychiatrists, allergy doctors, skin doctors and others who specialize in one area of health care.

During the last 6 months you were enrolled in [MEDICARE HEALTH PLAN NAME], were you seeing a specialist on a regular basis?

1 ☐ Yes

2 ☐ No → **Go to Question 27**

26. When you changed from [MEDICARE HEALTH PLAN NAME] to the health insurance you have now, did you have to stop seeing your specialist?

1 ☐ Yes

2 ☐ No

-3 ☐ I did not need to see a specialist

27. Since you left [MEDICARE HEALTH PLAN NAME], have you had any trouble getting health care that you wanted or needed?

1 ☐ Yes

2 ☐ No

-3 ☐ I have not tried to get any health care since I left [MEDICARE HEALTH PLAN NAME]

28. **Since you left [MEDICARE HEALTH PLAN NAME], have you delayed seeking medical care because you were worried about the cost?**

1 ☐ Yes

2 ☐ No

-3 ☐ I have not needed any medical care since I left [MEDICARE HEALTH PLAN NAME]

29. **Since you left [MEDICARE HEALTH PLAN NAME], were any medicines prescribed for you that you did not get?**

1 ☐ Yes

2 ☐ No → **Go to Question 31**

-3 ☐ I have not needed any prescription medicines since I left that plan → **Go to Question 31**

30. **What was the <u>main</u> reason you did not get the medicine? (Please mark only one answer.)**

1 ☐ I didn't think the medicine was necessary

2 ☐ I felt better and didn't need the medicine

3 ☐ I didn't have a way to get the medicine

4 ☐ I don't like to take medicine

5 ☐ It costs too much

6 ☐ Some other reason (Please specify)_____

_____

ABOUT YOU

This last set of questions is about you. These questions will help us learn about the people who answered the survey. This information will be kept confidential.

31. **In general, how would you rate <u>your overall health</u> now?**

1 ☐ Excellent

2 ☐ Very good

3 ☐ Good

4 ☐ Fair

5 ☐ Poor

32. What is the highest grade or level of school that you have completed?

1 ☐ 8th grade or less

2 ☐ Some high school, but did not graduate

3 ☐ High school graduate or GED

4 ☐ Some college or 2-year degree

5 ☐ 4-year college graduate

6 ☐ More than 4-year college degree

33. During the past 12 months, were you a patient in a hospital overnight or longer?

1 ☐ Yes

2 ☐ No

34. Are you of Hispanic or Latino origin or descent?

1 ☐ Yes, Hispanic or Latino

2 ☐ No, not Hispanic or Latino

35. What is your race? Please mark one or more boxes.

1 ☐ White

2 ☐ Black or African-American

3 ☐ Asian

4 ☐ Native Hawaiian or other Pacific Islander

5 ☐ American Indian or Alaska Native

36. Did anyone help you complete this survey?

1 ☐ Yes

2 ☐ No

THANK YOU

Please mail your completed survey in the postage-paid envelope.

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